



SCOUTS CANADA 22nd WORLD JAMBOREE - SWEDEN

Dear Doctor,

Your patient has applied to participate as a member of the **Canadian Contingent at Scouts Canada's 22nd World Jamboree in Sweden**. This event will be taking place between the 27th of July, and the 8th of August, 2011 near Krinstianstad, Sweden. The Jamboree site is situated in a large field which is partially surrounded by Swedish forestry. The participants will be expected to walk long distances, and will also be required to sleep in tents, on the ground, in an area with about 40,000 other participants. There will be no electricity available in the areas where these participants will be camping. The climate in Sweden during this season is variable, with a mix of rain, sun and some cool nights.

Previous experience at similar events has taught us that the aforementioned conditions are not always well suited for the physical and mental capacity of some individuals. We would appreciate your opinion of your patient's capabilities at this event. Please review and revise the preliminary medical information provided on your patient's registration form to ensure that it is current, before responding to the questions asked in the Health and Fitness Statement that follows herein:

Thank you for your assistance. 22nd World Jamboree

HEALTH AND FITNESS STATEMENT

Name of participant

Date of birth (dd/mm/yyyy)

Mailing address

Home telephone number

After reviewing the medical records for the above mentioned participant, I am confident that he/she would be physically and mentally capable of participating in the 22nd World Jamboree in Sweden.

I have the following concerns regarding the health of the above mentioned participant:

The following situations or factors may permit the above mentioned individual from participating in this event:

The above mentioned individual is not physically or mentally capable of taking part in this event.

I would like to discuss with you the above mentioned participant's health. Please contact me:

Name of Physician:

Telephone:

Address of Physician:

Signature of Physician



Please Print All Information