

CAMPER MEDICAL FORM

Must be completed by Health Care Provider and signed by a Physician, Nurse Practitioner or Physician Assistant.
Include Up-to-Date Immunization Records.
Please Be As Detailed As Possible And Answer All Questions.

Today's Date ____/____/____

Camper's Name: _____ (First) (MI) (Last) Camper's Date of Birth: ____/____/____

GENERAL INFORMATION

1 Primary Diagnosis: _____ Date of Dx ____/____/____

Asthma, please specify NIH classification: Mild Intermittent Mild Persistent

Moderate Persistent Severe Persistent

Burn survivor, please specify degree: First Second Third Percent Coverage _____

Cancer, please specify treatment: Active Treatment Maintenance Therapy

No Treatment Date of Last Treatment: _____

Hemophilia, please specify type and NIH classification: A B Mild Moderate Severe

Transplant, please specify type: Bone Marrow Heart Kidney Lung Other

Date of Transplant _____

2 Secondary Diagnosis: _____

3 Drug Allergies and Reactions: _____

4 Other Allergies (i.e. Latex, bee sting) and significance: _____

PHYSICAL EXAM AND HISTORY

Ht _____ ft _____ in OR _____ cm Wt _____ lb OR _____ kg

5 Pertinent Findings: _____

6 MEDICATIONS: Please include by all routes, both routine and PRN, and attach additional sheet as needed.

| Medication | Dose | Route | Frequency |
|------------|------|-------|-----------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

7 List all previous surgeries: _____

CAMPER MEDICAL FORM continued

8 Does this child have: (Check all that apply)
 Central venous line If yes, type: _____ location: _____
 G-tube Insulin Pump TPN Colostomy Other _____
Orthotics, wheelchair or other assistive devices: Yes No Please list any physical limitations:

9 Is the child cognitively appropriate for his/her age? Yes No
If **NO**, at what (approximate) age does child function? _____

10 Has the child ever had: Chicken Pox Shingles Varicella Vaccine
Date of diagnosis or vaccination: (required) _____

11 Methicillin-resistant *Staphylococcus aureus* (MRSA) positive? (required) Yes No
If yes, date cleared: _____. Campers will not be accepted unless cleared.

12 Vancomycin-resistant Enterococcus (VRE) positive? (required) Yes No
If yes, date cleared: _____. Campers will not be accepted unless cleared.

13 If this child routinely receives lab work, please attach most recent lab results.
Please list any essential labs to be performed while the child is at camp.

14 How is this child affected by his/her diagnosis?

15 Please list any additional current medical problems or pertinent psychosocial information including any behavior problems that would affect the child's participation in a group or camp setting.

PHYSICIAN RECOMMENDATION

Physician's Statement: I have examined _____ and find him/her physically able to attend camp. I understand the above medical regimen will be followed while he/she is at camp.

Comments: _____

| | | |
|---------------------------------|--------------------------------------|------------------------|
| _____ Signature of Provider | _____ Print Name | ____/____/____ Date |
| _____ Practice / Clinic Name | _____ Hospital Affiliation | |
| () _____ Phone | () _____ Emergency/On Call Phone | () _____ Fax |