CAMPER MEDICAL FORM

Must be completed by Health Care Provider and signed by a Physician, Nurse Practitioner or Physician Assistant. If completed by parent, form will not be accepted. Include Up-to-Date Immunization Records. Please Be As Detailed As Possible And Answer All Questions.

Today's Date ____/____/____

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

GENERAL INFORMATION

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

2 **Secondary Diagnosis:** _____ Date of Dx ____/____/____

3 **Drug Allergies and Reactions:** _____

_____

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

_____

PHYSICAL EXAM AND HISTORY

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

Pertinent Findings On Physical Exam or attach recent H&P: _____

_____

_____

Pertinent Past Medical History: _____

_____

2 **Does this child have:** *(Check all that apply)*

◯ Central venous line or dialysis catheter If yes, type: _____ location: _____

◯ G-tube ◯ Insulin Pump ◯ TPN ◯ Colostomy ◯ CPAP/BiPAP ◯ Tracheostomy ◯ MACE

◯ Vagal Nerve Stimulator ◯ VP Shunt ◯ Baclofen Pump ◯ Other _____

Orthotics, wheelchair or other assistive devices: ◯ No ◯ Yes Please list: _____

Please provide any additional information about the above: _____

_____

3 **List all previous surgeries:** _____

_____

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

Medication	Dose	Route	Frequency

CAMPER MEDICAL FORM continued

DISEASE SPECIFIC INFORMATION

Has this child been treated for:

1. **Asthma**
   ☐ No ☐ Yes → ☐ Mild ☐ Moderate ☐ Severe
2. **Burns**
   ☐ No ☐ Yes → ☐ First ☐ Second ☐ Third % affected: _____
3. **Cancer**
   ☐ No ☐ Yes → ☐ Active Tx ☐ Maintenance ☐ No Tx Date of last Tx: _____
4. **Hemophilia**
   ☐ No ☐ Yes → ☐ Mild ☐ Moderate ☐ Severe ☐ Type A ☐ Type B
5. **Kidney disease**
   ☐ No ☐ Yes → Is child on ☐ Peritoneal Dialysis ☐ Hemodialysis
6. **Seizures/epilepsy**
   ☐ No ☐ Yes → Last seizure: _____ How frequent: _____
7. **Transplant**
   ☐ No ☐ Yes → Type: _____ Date of transplant: _____

ADDITIONAL INFORMATION

1. **Has the child ever tested positive for Methicillin-resistant Staphlyococcus aureus (MRSA)?**
   ☐ No ☐ Yes → Date cleared: _____
2. **Has the child ever tested positive for Vancomycin-resistant Enterococcus (VRE)?**
   ☐ No ☐ Yes → Date cleared: _____
3. **Has the child ever had varicella/chicken pox?**
   ☐ No ☐ Yes → Date of vaccination or disease: _____
4. **Is the child exempt from immunizations due to immunosuppression?**
   ☐ No ☐ Yes, all vaccines ☐ Yes, only exempt for live vaccines
5. **Does the child have any limitations to participating in camp activities?**
   ☐ No ☐ Yes → Limitations: _____
6. **Is the child cognitively appropriate for his/her age?**
   ☐ Yes ☐ No → Approximately, what is the child's cognitive age?: _____
7. **Please list any additional information (medical, psychosocial, behavioral) that may be pertinent to the child's stay at camp:** _____

_____

PHYSICIAN STATEMENT

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.

Limitations to this child's participation in camp activities: _____

_____

_____

_____

_____	_____	____/____/____
Signature of Provider	*Print Name*	*Date*
_____	_____	
Practice / Clinic Name	*Hospital Affilitation*	
( ) _____	( ) _____	( ) _____
Phone	*Emergency/On Call Phone*	*Fax*