**CAMPER MEDICAL/BEHAVIOR HEALTH FORM**

*(To be completed and signed by* ***Specialist)***

Camper’s Name: DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Diagnosis.:

Primary Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Diagnoses:

Mental Health Diagnoses (including any recent hospitalizations for mental health):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the Camper been diagnosed with Autism? **🔾Yes 🔾 No**

Allergies:

Please describe all **current medical problems**:

**\*\*\*\*A copy of the most recent Office/Clinic Visit Notes must also be sent to Camp Boggy Creek\*\*\*\***

**MEDICATIONS**

Name: Dose: Route: Frequency:

Is the child’s development appropriate for his/her age? **🔾Yes 🔾 No**

**If no, at what age does s/he function?**

Pertinent Mental Health Information, including behavior problems that would affect child’s participation in a group: \_\_\_\_\_\_

Please specify any camp activity restrictions:

**Provider Statement:** I have examined this child and find him/her physically/mentally able to attend camp.

I understand that the above Treatment Plan will be followed at camp, unless other orders are received.

**Signature of Specialist Print Specialist Name Date**

**Treatment Center Emergency number Fax number**

**Specialist’s email address**

**(Camp Boggy Creek fax 352-483-2959)**

Camper Name

# **CAMPER WITH SEVERE ASTHMA FORM**

*(To be completed and signed by* ***Specialist)***

**Asthma Diagnosis:**

🔿 Mild Intermittent 🔿Mild Persistent 🔿Moderate Persistent 🔿Severe Persistent

Has this child been hospitalized because of asthma in the past year? Yes 🔿 No🔿

If yes, number of times

Has the child ever been in the ICU? Yes 🔿 No🔿

Has this child required systemic corticosteroid treatment (not inhaled) in the past year? Yes 🔿 No🔿

If yes, number of times \_\_\_\_\_\_\_\_\_\_\_

Does child have exercise induced asthma? Yes 🔿 No🔿

Known asthma triggers:

Peak Flow Zones (if done): (Please send Peak Flow meter with child if done daily)

Green Yellow Red *OR* Personal Best

PFT’s (if available): FVC FEV1

**History of Anaphylaxis?** Yes 🔿 No🔿 **If yes, please describe**

Known Food Allergies:

Known Drug Allergies:

Can the child participate without restriction in a camp program designed for children with pulmonary

problems? Yes 🔿 No🔿 If no, explain limitations

Please indicate any additional instructions or medications:

\_\_

**Signature of Specialist Print Specialist Name Date**

