**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)**

**Campers Name**: **Camper with Bleeding Disorder Medical Form**

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

**For summer camp, each child must bring enough factor for one week’s use, if on prophylaxis, PLUS two (2) additional “major bleed” doses. NO EXCEPTIONS**

What type of bleeding disorder does the child have?

Hemophilia A (Factor VIII deficiency) Hemophilia B (Factor IX deficiency)

Other bleeding disorder:

How severe is the child’s bleeding disorder (Factor level)?

Does the child receive prophylactic infusions of factor at home? **🔾Yes 🔾 No**

If not on home prophylaxis, do you recommend prophylactic infusions while at camp or before high risk activities, such as Horseback Riding or the Tower/High Ropes course? **🔾Yes 🔾 No**

What brand of factor is used?

**Dose:** Prophylactic:

Minor bleeds (soft tissue or muscle)

Major bleeds or joint bleeds

Trauma or head injury

**Name, location and phone number of Factor Supplier**  \_\_\_\_\_\_\_\_\_\_\_\_

Can any other brand be used in case of emergency? **🔾Yes 🔾 No** (Which )

Does this child require pre-medication for factor infusion? **🔾Yes 🔾 No**

If yes, medication to be given, dose, route of administration and how long before giving factor:

Does this child self-infuse? **🔾Yes 🔾 No**  **🔾** With assistance

Would like to learn **🔾Yes 🔾 No** (Home infusion option)

Does child use any other medications for other types of bleeding, i.e., mouth or nose bleeds? **🔾Yes 🔾 No**

Type of medication and dosage amount:

Recent surgeries:

Are there any target joints?

**COMPLETE IF CAMPER HAS A CENTRAL VENOUS CATHETER OR OTHER DEVICES**

Type of Catheter:

Please specify instructions for Care of Catheter (flush schedule, etc):

What, if any medications are to be infused into this line during the camp period?

Other Medical Devices (please describe & give care instructions)

**Signature of Specialist Print Specialist Name Date**

