**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’s name:

**Camper with Gastrointestinal Illness**

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

Has the camper been hospitalized because of GI issues in the past year?

If yes, how many times?

Does child have a colostomy? **🔿Yes 🔿No** If yes, is assistance required? **🔿Yes 🔿No**

Has camper had any intravenous (IV) or oral steroid in the past year? **🔿Yes 🔿No**

If yes how many times? Medication/Dosage

Has camper had any Remicade Infusions in the past 6 months? **🔿Yes 🔿No**

**Disease Activity:**

Abdominal Pain: None Mild/Brief Moderate/Severe (affects activities)

Stools: 0-3 Liquid/no blood 0-3 Semi formed/small blood >6/Liquid/gross bleeding

Patient Functioning: Well Occasionally limited Activity frequently limited

 Weight: Stable Weight loss (1-9 %) Weight loss (> 10 %)

 Perirectal Disease: None Indolent Active fistula/abscess

 Abdomen: NTND Mild tenderness Tenderness w/mass

How often does camper experience fever & vomiting? **🔿**Weekly **🔿** Monthly **🔿**Yearly

Any history of arthritis or joint pain? **🔿Yes 🔿No**

Date of most recent lab studies and results:

 Hct: Sed rate: Albumin:

Please specify any camp activity restrictions:

Any additional instructions or concerns?

**Signature of Specialist Print Specialist Name Date**

