**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 HEART DISEASE MEDICAL FORM

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

Cardiac Diagnosis:

Other Diagnoses:

Previous Surgeries:

Date: Procedure:

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

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

**Heart Transplant? 🔾Yes 🔾 No If yes, give date: Heart Heart/Lung**

**History of arrhythmias? 🔾Yes 🔾 No**

If yes, type of arrhythmia and frequency:

 Treated with:

**Pacemaker? 🔾Yes 🔾 No If yes, what type?**

Date and results of last stress test:

Anticoagulants: ASA\_\_\_\_ Coumadin\_\_\_\_ Other \_\_\_\_\_\_\_

Does child have pulmonary hypertension? **🔾Yes 🔾 No**

 If yes, is child on continuous infusion? **🔾Yes 🔾 No**

 Other treatments for PH?

**Usual saturation: Usual Hemoglobin:**

**Decreased ventricular function?: None\_\_\_\_ RV\_\_\_\_ LV\_\_\_\_ SV\_\_\_\_**

**Summary of last Echo report:**

**Please specify any camp activity restrictions:**

**Any other pertinent cardiac history?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Specialist Print Specialist Name Date

