**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:

**Immune DEFICIENCY SPECIFIC information**

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

Diagnoses:

Complications:

Recent Labs: Date H/H WBC

Segs Bands Lymphs Platelets

Significant Abnormal Labs: \_\_\_\_\_

PPD Date Negative Positive If positive, give details of treatment and contagiousness \_\_\_\_\_\_\_\_\_\_

Chronic diarrhea? **🔾YES 🔾 NO**

**FOR CHILDREN WITH ACQUIRED IMMUNE DEFICIENCY / HIV INFECTION**

Viral load: CD4 count Date

How was child infected? Vertically acquired Other

Does child know his/her diagnosis? **🔾YES 🔾 NO** If yes, how long has s/he known?

What terms does child use to describe his/her illness?

Is child comfortable with disclosure issues? **🔾YES 🔾 NO**

**Signature of Specialist Print Specialist Name Date**

