**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)**

**Camp Boggy Creek Oncology form**

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

**Camper’s Name**: D.O.B.

Type of Cancer: Date of Diagnosis:

Presently on treatment: **🔾Yes 🔾 No**

If off treatment, how long?

History of transfusion reaction? **🔾Yes 🔾 No**

Any pre-medication required?

Tylenol: mg Solu-Medrol: mg

What medications are recommended for Pain Management?

Nausea / vomiting?

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

**(PLEASE SEND CENTRAL LINE SUPPLIES WITH CHILD TO CAMP)**

Type of Catheter: May line be used to draw blood? **🔾Yes 🔾 No**

Other Medical Devices (please describe & give care instructions)

How much help will camper need in caring for these devices?

**Does camper need oxygen or other home medical equipment needs?**

**Oxygen: Continuously\_\_\_\_\_\_ Nighttime Flow rate?**

**Name of Equipment Company:**

**Address:**

**Phone number:**

**Contact person:**

**Signature of Specialist Print Specialist Name Date**

