**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 TRANSPLANT FORM**

***Heart Transplant should apply for the Heart Camp, Kidney Transplant should apply for Kidney Camp***

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

Organ(s) transplanted: Date of Transplant:

Transplant Doctor­­­­­­­­­­­­­­­­ Hospital \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Coordinator Phone number

History of rejection(s)? **🔾Yes 🔾No**

If yes, date of last rejection: Treated with:

Medical or surgical complications since transplant?

Anticoagulants: 🔾ASA 🔾Coumadin 🔾Other

Does your child have diabetes? 🔾Yes 🔾No If yes, Insulin dependent?

Name and phone # of the endocrinologist that manages your child’s diabetes:

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

 Medications used to treat:

 BP parameters to call transplant center with:

Please specify any camp activity restrictions:

Any other pertinent history?

Labs:

*Please fill in lab results that we should be aware of (or attach copy)*

 *WBC: \_\_\_\_\_\_, ANC:\_\_\_\_\_\_, Platelet:\_\_\_\_\_*

Varicella titers: \_\_\_\_\_\_\_\_\_\_\_\_ Measles titers: \_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of lab draws: Monthly\_\_\_\_\_\_\_ Weekly\_\_\_\_\_\_\_

Next labs due on: \_\_\_\_\_\_\_\_ Labs to be drawn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any special handling?

**Signature of Specialist Print Specialist Name Date**

