# CAMP ONE STEP by CHILDREN'S ONCOLOGY SERVICES

**PLEASE fill out ALL pages of the application COMPLETELY and PRINT CLEARLY**

## Physical Examination - To be completed by the Physician/Advanced Practice Provider

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Name** | First MI Last | | | **Exam Date** | Month Day Year | | |
| Diagnosis | | | | DOB | Month Day Year | | |
| Initial date of diagnosis | Month Day Year | Height (cm) | | Weight (kg) | | Blood Pressure | |
| Currently on therapy for cancer? | Please Sele | **If yes, please attach a copy of the child s road map.** | If no, when was therapy completed? | | | | |
| Treatment protocol | | | | | | | |

| | Normal | Abnormal | Comment (required if abnormal) |
|---|---|---|---|
| General | | | |
| Skin | | | |
| HEENT | | | |
| Lungs | | | |
| Heart/CV | | | |
| Abdomen | | | |
| Extremities | | | |
| Neurological | | | |
| Other | | | |

| **ALLERGIES:** (If more space is needed, please attach additional page(s) and continue) | | | |
|---|---|---|---|
| 1. | | 6. | |
| 2. | | 7. | |
| 3. | | 8. | |
| 4. | | 9. | |
| 5. | | 10. | |

**LABORATORY VALUES:** ☐ N/A

| | Normal | Abnormal | Comment (required if abnormal) |
|---|---|---|---|
| CBC | | | |
| Chemistries | | | |

What labs, if any, will this camper require during the camp session and when? _____

Labs needed during session should be faxed to the following number: _____

| **Medical Devices** | | | |
|---|---|---|---|
| Port | ☐ | Omaya Reservoir | ☐ |
| Hickman/Broviac/PICC Line | ☐ | NG Tube | ☐ |
| VP Shunt | ☐ | G-Tube | ☐ |
| Other: _____ | | | |

| Health Issues | |
|---|---|
| Cytopenias (specify below) □ | Clotting Disorder □ |
| Seizures □ | Chronic Pain □ |
| Peripheral Neuropathy □ | Nutritional Concerns □ |
| Avascular Necrosis □ | Mobility Issues □ |
| Autism □ | Cognitive Issues □ |
| ADD □ | Aniety □ |
| Bleeding Disorder □ | Depression □ |

Other Concerns (or explain from above):

_____

_____

**MEDICATIONS:** (Please include routine and PRN medications.)

☐ **See Attached**

| Medication | Dose | Route | Frequency |
|---|---|---|---|
| | | | |
| | | | |
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**Program Approval** (please ✓ the appropriate programs) **Note: You may approve multiple programs.**

**On the basis of this examination, I approve this child's participation in the following Camp One Step program(s):**

☐ Summer Camp
☐ Winter Camp
☐ Washington D.C. Program
☐ Utah Ski Program
☐ Dude Ranch Program
☐ Utah Adventure Program
☐ Chicago Day Camp

| Please Indicate restrictions (if any): | |
|---|---|
| □ No Restrictions | □ No Tubing or Sledding |
| □ No Contact Sports | □ No Downhill Skiing or Snowboarding |
| □ No High-Impact Sports | □ Other: _____ |

This physical exam may serve for any Camp One Step program within a year of the exam date, **if the camper has completed treatment for cancer, and IF the programs the child is planning on attending are checked for approval by the clinician**.

| **Physician/APP Signature** | _____ Date (Mo – Day - Yr) |
|---|---|