

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
Height (cm)		Weight (kg)	BP	DOB	Month	Day	Year

	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.	

Health Issues

Cytopenias (specify below) <input type="checkbox"/>	Clotting Disorder <input type="checkbox"/>
Seizures <input type="checkbox"/>	Chronic Pain <input type="checkbox"/>
Peripheral Neuropathy <input type="checkbox"/>	Nutritional Concerns <input type="checkbox"/>
Avascular Necrosis <input type="checkbox"/>	Mobility Issues <input type="checkbox"/>
Autism <input type="checkbox"/>	Cognitive Issues <input type="checkbox"/>
ADD <input type="checkbox"/>	Anxiety <input type="checkbox"/>
Bleeding Disorder <input type="checkbox"/>	Depression <input type="checkbox"/>

Other Concerns (or explain from above):

MEDICATIONS: (Please include routine and PRN medications.)

See Attached

Medication	Dose	Route	Frequency

Please Indicate restrictions (if any):

<input type="checkbox"/> No Restrictions	<input type="checkbox"/> No Tubing or Sledding
<input type="checkbox"/> No Contact Sports	<input type="checkbox"/> No Downhill Skiing or Snowboarding
<input type="checkbox"/> No High-Impact Sports	<input type="checkbox"/> Other: _____

This physical exam may serve for any Camp One Step camp within a year of the exam date.

Physician/APP Signature	
	Date (Mo - Day - Yr)