

2021 CAMPER MEDICAL FORM

*(Must be completed and signed by **hematologist**)*

Camper's Name: _____ DOB: _____ Wt.: _____

Primary Diagnosis: _____ Date of Diagnosis _____

Other Diagnoses: _____

Allergies: _____

Please describe any **current medical problems**. _____

PHYSICAL EXAM significant findings _____

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 Psychosocial Information, including any behavior problems that would affect child's participation in a group.

Please specify any camp activity restrictions _____

Physician's Statement: I have examined this child and find him/her physically able to attend camp.

I understand that the above Treatment Plan will be followed at camp, unless other orders are received.

A copy of the most recent OFFICE NOTES must also be sent to Camp Boggy Creek

Signature of Physician

Print Name

Date

Treatment Center

Emergency number

Fax number

Physician's email address

(Camp Boggy Creek fax 352-483-2959)



Camper's Name _____

CAMPER WITH SICKLE CELL DISEASE FORM

(To be completed by hematologist)

What hemoglobinopathy does the child have? (SS, SC, etc.) _____

Most recent Lab:

Date: _____ H/H: _____ Retic: _____

Usual oxygen saturation: _____

Has child had:

Chest Syndrome? _____

Stroke? _____

Gallstones? _____

Pica? _____

Does this child have any chronic abnormal physical findings? Yes No

If yes, describe: _____

CAMPER with A CENTRAL VENOUS CATHETER OR OTHER DEVICE

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

Please specify instructions for Care of Catheter (flush schedule etc.): _____

What, if any, medications are to be infused into this line during the camp period? _____

Other Medical Devices (please describe & give care instructions) _____

A copy of most recent office notes are also required.

Physician Signature

Print

Date

