

## 22Q DELETION - DIGEORGE SYNDROME

### CAMPER MEDICAL 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): \_\_\_\_\_

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? \_\_\_\_\_

Has the Camper been diagnosed with any behavioral, emotional, or mental health condition? ☐ Yes ☐ No

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 352-306-0674)

