

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)



Camper Name: _____

CAMPER WITH HEART DISEASE MEDICAL FORM

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

Cardiac Diagnosis: _____

Other Diagnoses: _____

Previous Surgeries:

Date: _____ Procedure: _____

Heart Transplant? ☐ Yes ☐ No If yes, give date: Heart _____ Heart/Lung _____

History of arrhythmias? ☐ Yes ☐ No

If yes, type of arrhythmia and frequency: _____

Treated with: _____

Pacemaker? ☐ Yes ☐ No If yes, what type? _____

Date and results of last stress test: _____

Anticoagulants: ASA _____ Coumadin _____ Other _____

Does child have pulmonary hypertension? ☐ Yes ☐ No

If yes, is child on continuous infusion? ☐ Yes ☐ No

Other treatments for PH? _____

Usual saturation: _____ Usual Hemoglobin: _____

Decreased ventricular function?: None _____ RV _____ LV _____ SV _____

Summary of last Echo report: _____

Please specify any camp activity restrictions: _____

Any other pertinent cardiac history? _____

Signature of Specialist

Print Specialist Name

Date

