Camp Boggy Creek -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_____

This child may interact with animals at the Camp petting farm ❍ **Yes** ❍ **No**

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 Bogy Creek

Signature of Physician, PA, ARNP	**Print Name**	**Date**
Treatment Center	**Emergency number**	**Fax number**

Physician, PA, ARNP 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, PA, ARNP Signature **Print** **Date**

(Camp Boggy Creek fax 352-483-2959)