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) □	Clotting Disorder □
Seizures □	Chronic Pain □
Peripheral Neuropathy □	Nutritional Concerns □
Avascular Necrosis □	Mobility Issues □
Autism □	Cognitive Issues □
ADD □	Aniety □
Bleeding Disorder □	Depression □

Other Concerns (or explain from above):

_____

_____

MEDICATIONS: (Please include routine and PRN medications.)

☐ **See Attached**

Medication	Dose	Route	Frequency

Please Indicate restrictions (if any):	
□ No Restrictions	□ No Tubing or Sledding
□ No Contact Sports	□ No Downhill Skiing or Snowboarding
□ No High-Impact Sports	□ Other: _____

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

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