Camp Sunshine 2017 Camper Physical Health Form

<u>PLEASE NOTE: This form is to be completed and signed by the camper's physician/PNP.</u> If the camper is currently on therapy, this must be completed by a member of his/her oncology team. If off therapy, this form can be completed by a pediatrician or family doctor. YOUR APPLICATION IS CONSIDERED INCOMPLETE UNTIL THIS PAGE IS RECEIVED.

Camper Name				Age at Camp	
-	first	middle	last		
Diagnosis				Date of	Diagnosis//
□ On Therapy	□ Off Therapy	y – date of final treatment	🗆 Rela	pse – date	🗆 BMT – date

This camper has a □ Port □ Central Line*/** □ N/A

*Please send the necessary supplies for central line care and flushing as well as daily dressing changes.

** I give permission for the camper to swim in the pool with the understanding that an occlusive dressing must be worn over the central line and changed immediately after swimming. MD/PNP signature ______

Medications

The medical staff will store and administer any medications needed during the camp week. <u>Camper's medication should be sent to</u> <u>camp in their original, labeled pharmacy container with written instructions</u>. It is expected that each family will supply in advance any routine medications needed.

□ Camper takes no medication on a routine basis

□ Camper needs pre-medications prior to receiving blood products. *

* Please list pre-medication(s) needed prior to receiving blood products: ____

Camper takes the following medications on a routine basis:

Use additional sheets as necessary to describe the care needed for your child.

*Please photocopy front and back of health insurance card and immunization form and attach to this form.

Medication to be taken	Dosage	Taken at These Times			Purpose
		AM	Noon	PM	
		Ť			

PHYSICIAN'S RECCOMENDATIONS & RESTRICTIONS

I examined			on			
camper's f			DOB	date of most recent e	examination	
Weight(kg)	Height(cm)			BP		
Allergies:						
Last blood count : Date	Hgb	Hct _	WBC	Platel	ets	
Differential or ANC	Varic	ella Titer _				
Date of last Tetanus shot (<mark>required</mark>)		Colonization of VRE: (circle one) yes	no	
Current physical and medical	condition:					

Current chemotherapy. Please include a copy of current chemotherapy roadmap or regimen.

Physician should write an order describing the dose and method of administration (including chemotherapy, TPN, antibiotics or other infusions). It is necessary for the camper's parent & healthcare team to arrange the transport of these medications to camp.

Any medically-prescribed meal plan or dietary restrictions:

Description of any limitation, concern or restriction on camp activities:

I hereby verify that the information on the above form and preceding forms concerning health matters and medications is correct. In my opinion, this child is able to participate in Camp Sunshine's Summer Camp and Year Round Programs.

Signature of Physician/Practitioner_____

Print Name _____ Date _____

Phone: _____

FOR CAMP SUNSHINE MEDICAL STAFF SCREENING USE ONLY

FORM REVIEWED BY:	MEDICATIONS RECEIVED:
DATE:	
UPDATES TO HEALTH HISTORY NOTED: YES NO NONE ADDITIONAL COMMENTS:	