Camp Sunshine. 1850 Clairmont Road. Decatur, GA 30033
Phone. 404.325.7979 Fax. 404.325.7929
www.mycampsunshine.com

Camp Sunshine 2019
Camper Physical Health Form

PLEASE NOTE: This form front and back is to be completed and signed by the camper's physician/PNP/PA. 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 _____ **Birth Date**_____ **Age at Camp** ____
first middle last

Diagnosis _____ Date **of Diagnosis** _____/_____/_____

☐ **On Therapy** ☐ **Off Therapy – date of final treatment** _____ ☐ **Relapse – 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** _____

☐ **Camper needs pre-medications prior to receiving blood products. ***
*** Please list pre-medication(s) needed prior to receiving blood products:** _____

PHYSICIAN'S RECCOMENDATIONS & RESTRICTIONS

I examined _____ on _____
camper's full name *date of most recent examination*

Weight(kg) _____ Height(cm) _____ BP _____

Allergies: _____

Date of last Tetanus shot (**required**) _____

Current physical and medical condition:

_____

_____

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 this form 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* _____

Treatment Center/Clinic:
☐ *CHOA-Egleston (404)785-1200* ☐ CHOA-Scottish Rite (404)785-3240
☐ Children's Memorial Hospital of Savannah (912) 350-8427
☐ **O**ther: Name_____ Phone Number_____

_____

Special Equipment/Ambulatory Needs: Check all that apply.

□ None □ Wheelchair □ Walker □ Crutches □ Prosthesis □ Orthotics □ White Cane □ Hearing Aids □ Glasses □ Contacts

□ Additional Special Needs _____

Please list any physical restrictions or activity limitations (i.e. no swimming, no prolonged sun exposure, no competitive sports, limb amputation, difficulty walking distances, vision or hearing loss: _____

_____

Medications

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

□ Camper takes NO medication on a routine basis

□ Camper takes medications

□ Camper is not on Chemotherapy

□ Camper is ON CHEMOTHERAPY: Protocol_____; Approximate end date_____

***Current chemotherapy roadmap should be faxed 2 weeks prior to camp.**

***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._____**

_____

□ Camper takes the following medications on a routine basis:

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

***Signature of Physician/Practitioner*_____ *date*_____**