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):_____
_____

Has the Camper been diagnosed with Autism? ❍ **Yes** ❍ **No**
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? _____

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 352-483-2959)

Camper Name_____

CAMPER WITH SEVERE ASTHMA FORM

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

Asthma Diagnosis:

❍ Mild Intermittent ❍Mild Persistent ❍Moderate Persistent ❍Severe Persistent

Has this child been hospitalized because of asthma in the past year? Yes ❍ No❍
If yes, number of times _____

Has the child ever been in the ICU? Yes ❍ No❍

Has this child required systemic corticosteroid treatment (not inhaled) in the past year? Yes ❍ No❍

If yes, number of times _____

Does child have exercise induced asthma? Yes ❍ No❍
Known asthma triggers: _____

_____

Peak Flow Zones (if done): (Please send Peak Flow meter with child if done daily)
Green _____ Yellow_____ Red_____ *OR* Personal Best _____

PFT's (if available): FVC_____ FEV_1_____

History of Anaphylaxis? Yes ❍ No❍ **If yes, please describe**_____

_____

Known Food Allergies: _____

Known Drug Allergies: _____

Can the child participate without restriction in a camp program designed for children with pulmonary problems? Yes ❍ No❍ If no, explain limitations_____

_____

Please indicate any additional instructions or medications: _____

_____

_____ _____ _____

Signature of Specialist **Print Specialist Name** **Date**

CAMP Boggy CREEK