

# 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:
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_____	_____	_____	_____
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_____	_____	_____	_____
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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's Name \_\_\_\_\_

**CAMPER WITH SICKLE CELL DISEASE FORM**

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

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) \_\_\_\_\_

\_\_\_\_\_  
Signature of Specialist

\_\_\_\_\_  
Print Specialist Name

\_\_\_\_\_  
Date

