

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 TRANSPLANT FORM

*Heart Transplant should apply for the Heart Camp, Kidney Transplant should apply for Kidney Camp
(To be completed and signed by **Specialist**)*

Organ(s) transplanted: _____ Date of Transplant: _____

Transplant Doctor _____ Hospital _____

Coordinator _____ Phone number _____

History of rejection(s)? Yes No

If yes, date of last rejection: _____ Treated with: _____

Medical or surgical complications since transplant? _____

Anticoagulants: ASA Coumadin Other

Does your child have diabetes? Yes No If yes, Insulin dependent? _____

Name and phone # of the endocrinologist that manages your child's diabetes: _____

Does your child have hypertension? Yes No

Medications used to treat: _____

BP parameters to call transplant center with: _____

Please specify any camp activity restrictions: _____

Any other pertinent history? _____

Labs:

Please fill in lab results that we should be aware of (or attach copy)

WBC: _____, ANC: _____, Platelet: _____

Varicella titers: _____ Measles titers: _____

Frequency of lab draws: Monthly _____ Weekly _____

Next labs due on: _____ Labs to be drawn: _____

Any special handling? _____

Signature of Specialist

Print Specialist Name

Date

