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)

Camp Boggy Creek Oncology form

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

Camper's Name:_____ D.O.B. _____

Type of Cancer: _____ Date of Diagnosis:_____

Presently on treatment: ❍ **Yes** ❍ **No**

If off treatment, how long? _____

History of transfusion reaction? ❍ **Yes** ❍ **No**

Any pre-medication required?

Tylenol: _____mg Solu-Medrol: _____mg

What medications are recommended for Pain Management? _____

Nausea / vomiting? _____

COMPLETE IF CAMPER HAS A CENTRAL VENOUS CATHETER OR OTHER DEVICES

(PLEASE SEND CENTRAL LINE SUPPLIES WITH CHILD TO CAMP)

Type of Catheter: _____May line be used to draw blood? ❍ **Yes** ❍ **No**

Other Medical Devices (please describe & give care instructions)_____

_____

How much help will camper need in caring for these devices? _____

_____

Does camper need oxygen or other home medical equipment needs?

Oxygen: Continuously_____ Nighttime ___Flow rate? _____

Name of Equipment Company: _____

Address:_____

Phone number:_____

Contact person:_____

_____ _____ _____

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