CAMPER MEDICAL FORM

Must be completed by health care provider and signed by a Physician, Nurse Practitioner, or Physician Assistant. Please include latest progress note and vaccine record (if applicable). Fax to 336.495.2045

Name:_____ Date of Birth:_____
(First) (MI) (Last)

GENERAL INFORMATION

Primary Diagnosis:_____ Date of Dx: _____

Secondary Diagnosis:_____ Date of Dx: _____

Allergies (severity):_____

PHYSICAL EXAM AND HISTORY

Height:_____ft _____in /_____cm Weight: _____ lb /_____kg

Pertinent findings on physical exam or attach recent H&P:_____

Pertinent past medical history:_____

List surgeries:_____

Does this child have: (Check all that apply)

☐ Central venous line or dialysis catheter? If yes, type:_____

☐ G-tube ☐ Insulin pump ☐ TPN ☐ Colostomy ☐ CPAP/BiPAP ☐ Tracheostomy ☐ MACE

☐ Vagal Nerve Stimulator ☐ VP Shunt ☐ Baclofen Pump ☐ Other:_____

Has this child been treated for:

Asthma ☐ No ☐ Yes → ☐ Mild ☐ Moderate ☐ Severe

Cancer ☐ No ☐ Yes → ☐ Active Tx ☐ Maintenance ☐ No Tx ☐ Date of last Tx:_____

Hemophilia ☐ No ☐ Yes → ☐ Mild ☐ Moderate ☐ Severe ☐ Type A ☐ Type B

Kidney Disease ☐ No ☐ Yes → Is child on ☐ Peritoneal Dialysis ☐ Hemodialysis

Seizures/Epilepsy ☐ No ☐ Yes → Last seizure:_____ How frequent:_____

Transplant ☐ No ☐ Yes → Type:_____ Date of transplant:_____

MEDICATIONS

Medication	Dose	Route	Frequency

Ever tested postive for MRSA or VRE? ☐ No ☐ Yes Date cleared: _____

Exempt from immunizations due to immunosuppression? ☐ No ☐ Yes, all vaccines ☐ Yes, only live vaccines

Cognitively appropriate for his/her age? ☐ Yes ☐ No If no, what is approx. cognitive age? _____

Please list any additional information (medical, psychosocial, behavioral) that may be pertinent to the child's stay at camp: _____

Please describe this camper's medical action plan specific to disease or allergy: _____

Any special suggestions for this camper: _____

Can they participate in: ☐ Horseback riding ☐ Waterpark ☐ High ropes course (approx. age 13+)
☐ Tethered hot air balloon ☐ Kiss a fish ☐ Zipline (approx. age 11+)

Other activity limitations or restrictions: _____

Physician's Statement: I have examined _____ and cleared him/her to attend Victory Junction. I understand the above medical regimen will be followed while he/she is at camp.

_____

Parent Contact Information: (please provide name, current cell phone number, and address)

_____	_____	_____
Signature of Provider	*Print Name*	*Date*
_____	_____	_____
Practice/Clinic Name	*Phone*	*Emergency/On Call Phone*

Please fax this form to Camper Admissions at 336.495.2045.
Please include latest progress note and vaccine record (if applicable).