

# 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)

\_\_\_\_\_  
Parent name and phone number

## 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 positive 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.

\_\_\_\_\_  
*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).**