

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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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 352-306-0674)

Camper Name: _____

CAMPER WITH HEART DISEASE MEDICAL FORM

(To be completed and signed by Specialist)

Cardiac Diagnosis: _____

Other Diagnoses: _____

Previous Surgeries:

Date: _____ Procedure: _____

Heart Transplant? Yes No If yes, give date: Heart _____ Heart/Lung _____

History of arrhythmias? Yes No

If yes, type of arrhythmia and frequency: _____

Treated with: _____

Pacemaker? Yes No If yes, what type? _____

Date and results of last stress test: _____

Anticoagulants: ASA _____ Coumadin _____ Other _____

Does child have pulmonary hypertension? Yes No

If yes, is child on continuous infusion? Yes No

Other treatments for PH? _____

Usual saturation: _____ Usual Hemoglobin: _____

Decreased ventricular function?: None _____ RV _____ LV _____ SV _____

Summary of last Echo report: _____

Please specify any camp activity restrictions: _____

Any other pertinent cardiac history? _____

Signature of Specialist

Print Specialist Name

Date

