

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 352-306-0674)

Camper Name _____

Camper with Kidney Disease Form

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

Diagnosis _____

Is child on dialysis? Yes No Type of dialysis Hemodialysis Peritoneal

Schedule of dialysis (i.e. MWF or 6 out of 7 days): _____

Etiology of ESRD: _____

Home dialysis unit: _____ Contact person: _____

Address _____ Phone: _____

Most recent lab data: Date: _____

Na⁺ _____ K⁺ _____ Cl⁻ _____ BUN _____ Creat _____

Ca⁺⁺ _____ Phos _____ Alb _____ Cholesterol profile _____

HCO₃⁻ _____ Hgb _____ Hct _____ WBC _____ Platelets _____

Hepatitis status and liver function results: _____

HIV status _____ Date _____ Other pertinent results _____

Transfusion reactions: Date _____ Product given: _____

Special dietary Rx: Protein _____ Na⁺ _____ K⁺ _____ Phos _____

Fluid limit _____ Supplements? _____

KIDNEY TRANSPLANT CAMPERS ONLY

Date of transplant: _____ Date of last rejection episode: _____

Details _____

Will labs need to be checked while at camp? Yes No

If yes, FAX results to: _____ Contact person _____

Phone: _____

Signature of Specialist

Print Specialist Name

Date



Camper Name _____

HEMODIALYSIS INSTRUCTIONS

Access type: Catheter ____ Fistula ____ Graft ____

Site: _____

Cath. vol.: _____cc Arterial _____cc Venous Lines: Adult ____ Pediatric ____

Dialyzer _____ Dialyzer surface area _____

Any dialyzer adverse reactions? _____

Treatments per week _____ Length of treatment _____

Dialysate Na⁺ ____ K⁺ ____ Ca⁺⁺ ____ Bicarb/acetate _____

Na⁺ modeling? Yes ____ No ____ Details: _____

Use of Lidocaine or EMLA? ____ Details: _____ QB ____ Dry wt _____

Heparinization: Initial ____ units, Maint. ____ units, Total ____ Stop time _____

Medications during dialysis: Epogen _____ Calcijex _____ Other _____

Usual pretreatment BP: ____/____ Usual post treatment BP: ____/____

Usual weight gain between dialysis _____ Usual UF achieved _____

Usual treatment for: Cramping? _____ Hypotension? _____

Any behavioral concerns during treatment? _____

PERITONEAL DIALYSIS INSTRUCTIONS

What brand of cyclor does the camper use? _____

What brand of supplies does camper use? _____

Company providing supplies? _____

Contact name: _____ Phone: _____

Who does the treatments for the patient? _____

Has patient had peritonitis? Yes ____ No ____ Dates and Treatment of most recent episode: _____

Campers showing S&S of peritonitis will be treated according to our protocol. Please specify any antibiotics/treatments you prefer not be used: _____

Usual additives: _____ Exit site protocol: _____ Tape sensitivity? _____

Special precautions for swimming _____

(our protocol calls for site cleansing and dressing change after every swim)

CAPD: Vol _____ Schedule _____ Dialysate Conc _____

CCPD: Vol of exchange _____ # of exchanges _____ Cyclor type _____

Dialysate: # liters 1.5%: _____ # liters 2.5%: _____ # liters 4.25%: _____

Exchange times: Fill _____ Dwell _____ Drain _____ Tubing - Adult/Peds? _____

Daytime dwell? Yes ____ No ____ If yes, volume _____ Conc _____

