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's Name_____

CAMPER WITH SICKLE CELL DISEASE FORM

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

What hemoglobinopathy does the child have? (SS, SC, etc.)_____

Most recent Lab:

Date: _____ H/H: _____ Retic: _____

Usual oxygen saturation: _____

Has child had:

Chest Syndrome? _____

Stroke?_____

Gallstones? _____

Pica? _____

Does this child have any chronic abnormal physical findings? ❍Yes ❍No

If yes, describe: _____

_____

CAMPER with A CENTRAL VENOUS CATHETER OR OTHER DEVICE

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

Please specify instructions for Care of Catheter (flush schedule etc.): _____

_____

What, if any, medications are to be infused into this line during the camp period?_____

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

_____ _____ _____

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