

2023 CAMPER MEDICAL FORM

*(Must be completed and signed by **Oncology office**)*

Camper's Name: _____ DOB: _____ Wt.: _____

Primary Diagnosis: _____ Date of Diagnosis _____

Other Diagnoses: _____

Allergies: _____

Please describe any **current medical problems**. _____

PHYSICAL EXAM significant findings _____

This child may interact with animals at the Camp petting farm Yes No

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 Psychosocial Information, including any behavior problems that would affect child's participation in a group.

Please specify any camp activity restrictions _____

Physician's Statement: I have examined this child and find him/her physically able to attend camp.

I understand that the above Treatment Plan will be followed at camp, unless other orders are received.

A copy of the most recent Oncology OFFICE NOTES is also required

Signature of Physician

Print Name

Date

Treatment Center

Emergency number

Fax number

Physician's email address

(Camp Boggy Creek fax 352-483-2959)



Camp Boggy Creek Oncology form
(To be completed by Oncology office)

Camper's Name: _____ D.O.B. _____

Type of Cancer: _____ Date of Diagnosis: _____

Presently on treatment: Yes No

If off treatment, how long? _____

History of transfusion reaction? Yes No

Any pre-medication required?

Tylenol: _____mg

Solumedrol: _____mg

What medications are recommended for Pain Management? _____

Nausea / vomiting? _____

COMPLETE IF CAMPER HAS A CENTRAL VENOUS CATHETER OR OTHER DEVICES

(PLEASE SEND CENTRAL LINE SUPPLIES WITH CHILD TO CAMP)

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

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

How much help will camper need in caring for these devices? _____

Does camper need oxygen or other home medical equipment needs?

Oxygen: Continuously _____ Nighttime _____ Flow rate? _____

Name of Equipment Company: _____

Address: _____

Phone number: _____

Contact person: _____

Signature of Physician

Print Name

Date

(Camp Boggy Creek fax 352-483-2959)

