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 352-483-2959)

Campers Name: ____

Camper with Bleeding Disorder Medical Form

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

For summer camp, each child must bring enough factor for one week's use, if on prophylaxis, PLUS two (2) additional "major bleed" doses. NO EXCEPTIONS

What type of bleeding disorder does the child have?

Hemophilia A (Factor VIII deficiency)____________ Hemophilia B (Factor IX deficiency)____________

Other bleeding disorder:____

How severe is the child's bleeding disorder (Factor level)?______________________________

Does the child receive prophylactic infusions of factor at home? ❍ **Yes** ❍ **No**

If not on home prophylaxis, do you recommend prophylactic infusions while at camp or before high risk activities, such as Horseback Riding or the Tower/High Ropes course? ❍ **Yes** ❍ **No**

What brand of factor is used? ______________________________

Dose: Prophylactic: ______________________________

Minor bleeds (soft tissue or muscle) ____________________

Major bleeds or joint bleeds ____________________

Trauma or head injury ____________________

Name, location and phone number of Factor Supplier ______________________________

____

Can any other brand be used in case of emergency? ❍ **Yes** ❍ **No** (Which____________________)

Does this child require pre-medication for factor infusion? ❍ **Yes** ❍ **No**

If yes, medication to be given, dose, route of administration and how long before giving factor: ____________

____

Does this child self-infuse? ❍ **Yes** ❍ **No** ❍ With assistance

Would like to learn ❍ **Yes** ❍ **No** (Home infusion option)

Does child use any other medications for other types of bleeding, i.e., mouth or nose bleeds? ❍ **Yes** ❍ **No**

Type of medication and dosage amount: ______________________________

Recent surgeries: ____

Are there any target joints? ____

COMPLETE IF CAMPER HAS A CENTRAL VENOUS CATHETER OR OTHER DEVICES

Type of Catheter: ____________________

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**