Camp Alphie

# Medical History *(patient)*

*(Please complete a form for EACH camper. Incomplete forms will be returned.)*

Child's Name: ______________________________________ Circle one: Male / Female

Date of Birth: __________________________ Age: ________ Today's Date: _____________

## Physician Information and Signature

Name of Primary Physician: _________________________________ Phone: ( ) __________________

Address: ________________________________ City: ____________________ State: _______ Zip: ________

*After Physical Examination, I certify this camper is not contagious and he/she may mix with immune-compromised children.* Physician Signature: ___________________________ Date: ______________

## Emergency Information

Please list two persons to contact in the event we cannot reach you.

1) ____________________________________ Relationship: _____________ Phone: ( ) ____________

2) ____________________________________ Relationship: _____________ Phone: ( ) ____________

Date of last tetanus shot: __________ My child has had chicken pox: YES / NO or SHOT ______
Date

Allergies (drugs, mold, insects, foods, etc.): ________________________________________________

Food restrictions: ____________________________________________________________________

Recent hospitalization/surgery (description & date): _____________________________________________

Medical problems (diabetes, asthma, hay fever, seizures, etc): ____________________________________

______________________________________________________________________________

Additional Information (physical disabilities, hearing loss, vision disturbance, etc.): _________________

______________________________________________________________________________

Insurance Company: _________________________________ Policy Number: ________________________

*Medical needs of our campers will be supervised by pediatricians from Texas Tech University School of Medicine in Amarillo and by an oncology nurse who will reside at camp. If there are any problems not related to routine camp illnesses/injuries, your primary physician will be contacted.*

# Medical History *(patient)*

My child, ______________________________, was diagnosed on (date) ____________________
with (please give specific type of cancer) ______________________________________________.

Date of last doctor's visit: ______________________________

Last blood count: HGB__________ HCT___________ WBC__________ PLTS__________

Differential______________________________

APPROXIMATE DATE OF CHEMO TREATMENT CLOSEST TO CAMP ____________________

Any physical restrictions or limitations to activity: (no prolonged exposure to sun, no competitive sports, etc.) ____________________________________________________________________

## Catheters

My child has a broviac / central line or other catheter: _____________________________________

This central line may be accessed by a physician/nurse if needed for lab work, therapy, etc. YES / NO

Any explanation? ____________________________________________________________________

My child has: permission to take a shower: YES / NO

permission to swim in a chlorinated pool: YES / NO

## Medications

List all medications that will be used at, or taken to, camp:

Drug name: ________________________ Dosage: _______________ Times: ________________

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Drug name: ________________________ Dosage: _______________ Times: ________________

Drug name: ________________________ Dosage: _______________ Times: ________________

**The camp nurse will supervise the administration of all medications.** Please send the medications to camp with **written instructions**. Medications will be kept in the infirmary for the safety of all campers and for documentation purposes. ***Chemotherapy medications, subcutaneous and/or intravenous meds must be supplied with written instructions, signed by your physician.***

Please list dressing changes or procedures required while at camp:____________________________
____________________________________________________________________________________

Please list any other information that will help us provide the best camp experience possible for your child:___________________________________________________________________________

**Parent Signature:** ________________________________________ **Date:**________________
**Physician Signature:** ______________________________________ **Date:**________________