RONALD MCDONALD CAMP 2019

Camp Dates: August 11-17

CAMPER PATIENT PHYSICAL

*****All campers must have this form completed by a physician/nurse practitioner and returned by the application deadline of May 1. If your child's physical appt. is scheduled after May 1 and July 31 due to insurance, you have already indicated the date on the online application and we will expect this form within a week of that date. If your appt. is scheduled after August 1 please contact us. Thank You!**

Patient's Name: _________________________________ Date: ________________

MEDICAL DIAGNOSIS ____

Date of diagnosis: __________________ Current Therapy: _________________________________

Date & type of most recent chemotherapy (last six months):_________________________________

Is it possible that your patient will be receiving chemotherapy within 2 weeks of camp?
Yes________ No________

**All on-therapy campers will be required to have a CBC done within a week of camp and campers with expected prolonged count suppression of thrombocytopenia requiring transfusions may not be eligible for camp. The camp medical staff will make the final decision regarding eligibility the week before camp.

Date off therapy:____

Date and site of last radiation therapy: ____

Date and site of previous surgeries: ____

Describe any physical/cognitive challenges and/or physical limitations/restrictions to activity (include crutches, wheelchair, prosthesis):____

____

Describe any allergies (type, reaction and management of reaction):

____

_____CAMPER TAKES NO MEDICATION ON A DAILY BASIS

ORAL MEDICATION

Drug Name & Strength	Dosage	Frequency	Reason for Taking

SUBCUTANEOUS(SQ)OR INTRAMUSCULAR (IM) INJECTION

Drug Name & Strength	Dosage	Route	Frequency	Reason

2019 PATIENT PHYSICAL
PAGE 2

PHYSICAL EXAMINATION Please have your child's physician/nurse practitioner fill this section out completely. It is required that all on-therapy patient campers have **physical exams within 6 months** of attending camp. Off-therapy patients must have a physical exam within **12 months** of attending camp.

PATIENTS NAME____ DOB _____/_____/______

Date of Exam: ______/_____/______ Height:___________ Weight:__________

Blood Pressure: ___________ Heart Rate: ___________ Respiratory Rate: _____________

System	Normal	Abnormal/Please explain
General		
HEENT		
Neck		
Lungs		
Heart		
Abdomen		
Neuro		
Skin		
GU		
Musculoskeletal		

Central Line: Y N. If Yes, type: ____

Other Comments:____

****

Doctor's/Nurse Practitioner's Statement: The patient above is physically able to engage in camp activities, except for physical limitations and restrictions listed above.

NP/ MD Signature ______________________________________ Date: _________________

Print Name ____

Address: ____

Phone: ____

<u>Parents: You have 2 options to return this form:</u>

1. Scan and upload to your child's application paperwork.

2. Email to camp@philarmh.org