

Happiness **Medical Form 3 for** **Is Camping Campers on Treatment**

Name: _____
Date of Birth: _____ Male Female
Session: _____



Please have your child's oncologist
complete this form and
return it to the camp office.

Cancer Diagnosis: _____ _____ _____	Physician's Name: _____ Physician's Phone: _____ Hospital Name: _____ Address: _____ City: _____ State/Province: _____ Zip/Postal Code: _____
In remission? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date? _____	
Currently on treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Last Chemotherapy/Radiation Treatment (include dates)

Current Medications

Does child have:	<input type="checkbox"/> Broviac	<input type="checkbox"/> MediPort	<input type="checkbox"/> PICC line	<input type="checkbox"/> NGT	<input type="checkbox"/> G-tube (feeding)	<input type="checkbox"/> Prosthesis (specify type)
Details:	_____ _____ _____					
Who cares for it?	_____					
Does the child help?	_____					

Physical Restrictions

Does child require any special care?

Should your child's counselor check in with the health center about allergies, dietary needs, eating habits or medical concerns? Yes No

Special Instructions/Treatment Needs (IVP chemotherapy, blood work, scheduled tests)

