

HAPPINESS IS CAMPING

62 Sunset Lake Road, Hardwick, NJ 07825

CAMPER HEALTH EXAM FORM A

(Must be completed by primary oncology team or primary care doctor.)

Name of Camper _____ Date of Exam _____

Date of Birth _____ Gender _____

Cancer Diagnosis _____ Date of Diagnosis _____

Is the Camper on Treatment? () Yes () No, date completed _____

Rec'd chemo () Yes () No Rec'd RT () Yes () No Transplant date (if applicable) _____

Brain tumor () No () Yes VP Shunt () No () Yes Seizure history () No () Yes

Varicella status (had varicella, vaccinated, immune by titer, susceptible) _____

Immunization status (***include a copy or indicate on hold 2° treatment**) _____

Surgical history _____

Other medical history (diabetes, asthma, psychiatric or behavioral issues, etc.) _____

Diet/nutrition (list any dietary restrictions) _____

Allergies _____

Medications (include name, dose, frequency and time of day given) _____

If there are any Over the Counter Medications that should **NOT** be administered at Camp please note them here:

Please list any limitations the Camper may have while at Camp _____

Treatments to be continued at Camp _____

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Name of Camper _____ Date of Exam _____

Review of Systems:

__ Patient is unable to communicate

General __ Normal __ Abnormal

Eyes __ Normal __ Abnormal

ENMT __ Normal __ Abnormal

Respiratory __ Normal __ Abnormal

Cardiovascular __ Normal __ Abnormal

Urologic __ Normal __ Abnormal

Gastrointestinal __ Normal __ Abnormal

Neurologic __ Normal __ Abnormal

Endocrine __ Normal __ Abnormal

Hematological __ Normal __ Abnormal

If abnormal, please comment _____

Physical Examination

General Appearance/nutritional status () NL () AB

IV Access () No () Yes Describe _____

NL	AB		NL	AB		NL	AB	
()	()	HEENT	()	()	Abdomen	()	()	Psycho/social dev
()	()	Dental	()	()	Genito-Urinary	()	()	Language
()	()	Neck	()	()	Extremities	()	()	Behavioral
()	()	Lymph	()	()	Back	()	()	Gross Motor
()	()	Lungs	()	()	Skin	()	()	Fine Motor
()	()	Cardiovasc	()	()	Neuro			

Describe abnormal findings:

Licensed Medical Personnel Authorization

I have reviewed the camper/sibling health history form and have discussed the camp program with the camper's/sibling's parent or guardian. It is my opinion that the camper/sibling is physically and emotionally fit to participate in an active camp program (except as noted above).

Printed name of licensed provider _____

Contact phone number for provider _____

Provider e-mail _____

Signature of licensed professional _____

****FOR CAMPERS ON TREATMENT HAPPINESS IS CAMPING WILL CONTACT YOU SEVERAL WEEKS BEFORE THE CAMP SESSION FOR AN UPDATED MEDICAL ASSESSMENT AND DETAILS OF WHAT THE CAMPER WILL NEED WHILE AT CAMP.****