Camper Name_____

CAMPER MEDICAL INFORMATION FORM
(must be completed and signed by physician)

I have examined: _____
(Patient's name)

In my opinion, the above patient's condition (circle one) does / does not preclude camp attendance:

_____ _____
(Signature of treating physician) (Treatment Facility)

Cancer Diagnosis: _____Primary Site: _____

Stage (Include sites of metastases): _____

Date of Initial Diagnosis: _____ Current Status: Remission Active Disease
(Circle One)

Date(s) and Site(s) of Recurrence_____

_____

Therapy Status: Off therapy On therapy
(Circle One)

If OFF therapy, date completed and protocol: _____

If ON therapy, Current ***Therapy, Protocol,*** and ***Phase***: _____

_____

_____

Please list most recent medications and dates: _____

_____

_____

Has child had a bone marrow transplant? YES NO
(Circle One)

Type of transplant: Autologous Allogenic Date of transplant: _____
(Circle One)

History of GVHD? YES NO Type of GVHD: Acute Chronic
(Circle One) (Circle One)

Current site of active GVHD: _____

Camper Name_____

Surgery: List all Dates/Sites/Procedures: _____

_____

_____

Radiation: List all Dates/Sites*:* _____

_____

Does child have a Central Access Line? If so, please specify: _____
Camp policy does not allow lake swimming. If the child has a C.V.L. or has had any surgery within the past 7 (seven) days, please ***specify in writing if camper has permission to swim***

_____

List all medications, dosages, frequency and specifics of administration to be given during camp.
Provide signed order sheet for chemotherapy, labs and other medications fluids and feedings:

DRUG	DOSE	ROUTE	DUE DATES

Tylenol PRN may be given at camp? YES NO
(Circle One)

Varicella Immune? YES NO STATUS UNKNOWN
(Circle one)

Labs to be drawn at camp (specify labs and dates): _____

If child may require transfusion during camp week, specify transfusion threshold/levels:

Camper Name_____

Hemoglobin: _____

Platelet Count: _____

Mode of transfusion: (Circle if applicable :) Irradiated Filtered

Please call: _____to make transfusion arrangements
(Name and phone number)

Special transfusion needs: _____

Transfusion may be given at: _____
(Name of hospital)

Date of Most Recent Blood Counts: _____

Hemoglobin: _____WBC: _____

Platelet: _____ ANC: _____

Medical Allergies: (List drugs and describe reaction)

Medication	Reaction

Seizures? _____

Are there any other underlying medical conditions? _____

_____

*Catheter flushing/dressing change schedule and routine: _____

_____

Camper Name_____

****PLEASE NOTE****

All catheter flushing and dressing supplies, feeding supplies or any other supplies that may be needed by the camper during the week must be labeled and brought with child to camp

Physician's Name: (Print Or Type):_____

Physician's Signature: _____

Address: _____

Phone: _____**Fax**: _____

Contact person at facility (nurse, nurse practitioner) _____

Daytime Phone_____ **Evening Phone**_____

Please return this form to the Beyond the Horizon Corporation:
Beyond the Horizon Corporation
402 Dahlia Dr
Brentwood, TN 37027

Or email to CHOapp@camphorizontn.org