CAMP SUNSHINE PHYSICAL EXAMINATION MEDICAL FORM

The following information should be provided by the Medical team treating the child.

*****PLEASE RETURN THIS COMPLETED FORM TO THE FAMILY.**

THIS FAMILY'S APPLICATION CANNOT BE PROCESSED UNTIL *ALL* APPLICABLE INFORMATION IS COMPLETE.

Child's Name: _____ **Date of Birth:** ___/___/___
Diagnosis: _____ **Date of Diagnosis:** ___/___/___
Allergies: _____ **Date of Examination:** ___/___/___

❶ **PLEASE ANSWER THE QUESTIONS BELOW THAT ARE APPLICABLE TO YOUR PATIENT'S DIAGNOSIS.**

❍ **Shwachman-Diamond syndrome**

Does the patient receive pancreatic enzyme replacement? ❑ Yes ❑ No If so, please specify _____

Does the patient require colony stimulating factor? ❑ Yes ❑ No If so, please specify _____

➲ Hematopoietic stem cell transplantation ❑ Not applicable

Has the patient undergone stem cell transplantation? ❑ Bone marrow ❑ Peripheral stem cell ❑ Cord blood

Donor: ❑ Related ❑ Unrelated Date of transplant ___/___/___

Have there been any complications related to the transplant? _____

❍ **Cancer/Hematologic Condition**

Is the child on active treatment?

❑ Yes: Date of most recent chemotherapy: ___/___/___ ❑ No: Date therapy completed: ___/___/___

➲ Brain Tumor ❑ Not applicable

Does the child have a VP shunt? ❑ Yes ❑ No Is it functioning? ❑ Yes ❑ No When was the last revision? _____

Does the child have seizures? ❑ Yes ❑ No What type and frequency? _____

Please describe any residual neurologic dysfunction: _____

➲ Bone Marrow/Stem Cell Transplantation

Has the child undergone hematopoietic cell transplantation? ❑ Yes ❑ No If yes: ❑ autologous ❑ allogeneic bone marrow

❑ Peripheral stem cell ❑ Cord blood Date of transplant ___/___/___

Have there been any complications related to the transplant? _____

❍ **Telomere Biology Disorder / Dyskeratosis congenital**

Is the patient on active treatment? ❑ Yes: Dates and nature of most recent therapy: _____

❑ No: Date therapy completed: ___/___/___

❍ **Fanconi Anemia**

Is the patient on active treatment? ❑ Yes Dates and nature of most recent therapy: _____

❑ No Date therapy completed: ___/___/___

❍ **Transplant History / Renal Disease**

Nature of the transplant _____ If liver or kidney, living related donor? ❑ Yes ❑ No

Date(s) of transplant: ___/___/___ Last episode of rejection: ___/___/___

Describe any surgery in the past year: _____

Describe any ongoing infusion protocols: _____

_____

Describe any percutaneous catheters: _____

Is child on CCPD? ❑ Yes ❑ No If the child is on CCPD, please describe the dialysis program: _____

EBV/CMV

(1) This child is seropositive for EBV. ❑ Yes ❑ No Describe any ongoing problems: _____

_____

(2) This child is seropositive for CMV. ❑ Yes ❑ No Describe any ongoing problems: _____

_____

(3) Is there ongoing PTLD? ❑ Yes ❑ No Please describe: _____

_____

❍ **Sickle cell disease**

Diagnosis: ¯ Hb SS ¯ Hb S-Thal ¯ Hb SC ¯ Other _____

Describe any physical disability or physical limitations affecting camp activity: _____

**Indoor Pool temperature is elevated for this session

➲ Bone Marrow/Stem Cell Transplantation

Has the child undergone hematopoietic cell transplantation? ❑ Yes ❑ No If yes: ❑ autologous ❑ allogeneic bone marrow

❑ Peripheral stem cell ❑ cord blood Date of transplant ___/___/___

Have there been any complications related to the transplant? _____

❍ **Lupus**

Organ systems involved: ❑ Skin ❑ Joints ❑ Muscle ❑ Kidney (WHO Class) _____

❑ Neurologic ❑ Hematologic ❑ Antiphospholipid syndrome ❑ Other _____

Describe any ongoing infusion protocols: _____

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❷ **CENTRAL VENOUS ACCESS** ❑ Not applicable

Type of access: ❑ Internal (Portacath/Infusaport/Mediport) ❑ External (Broviac/Hickman) ❑ PICC line

Special instructions regarding central line/port: _____

❸ **IS THE CHILD PERMITTED TO PARTICIPATE IN THE FOLLOWING ACTIVITIES AT CAMP?**

Swim in a chlorinated indoor heated pool? ❑ Yes ❑ No

Swim in lake water? ❑ Yes ❑ No

Engage in contact sports? ❑ Yes ❑ No

Climb on our climbing wall? ❑ Yes ❑ No

Participate in high elements on our ropes course? ❑ Yes ❑ No

Are there any restrictions or suggestions for this child? _____

Describe any disability or physical limitations affecting other camp activity: _____

❹ TRANSFUSIONS

Is the child on a transfusion protocol? ❑ Yes ❑ No Is the child likely to require transfusion during camp? ❑ Yes ❑ No

Has the child ever had a transfusion reaction? ❑ Yes ❑ No Transfusion history of note _____

What are guidelines for transfusion? _____

What preparation or pre-medication is required? _____

❺ COVID-19

In order to meet regulatory needs, we are documenting the COVID-19 vaccine status of every person on campus. This suggestion is from our governing body as a best practice recommendation as it relates to exposure protocol.

Has the child been vaccinated for COVID-19? ❑ Yes ❑ No

❻ VARICELLA (If the following information is not complete, this application cannot be reviewed.)

Please indicate*:* _____(1) This child is **IMMUNE** to varicella by reason of (check one or more):

❑ Clinical disease (varicella, herpes zoster) ❑ positive titer ❑ Varivax vaccine – **OR –**

_____(2) This child is **NOT IMMUNE** to varicella and the vaccine has not been administered to him/her.

In the event of a Varicella Exposure at Camp, will this child require VARIZIG and/or ACYCLOVIR? ❑ YES ❑ NO

NOTES: _____

❼ PHYSICAL EXAMINATION

Height: _____ Weight: _____ Pulse: _____ Respirations: _____ BP: _____/_____

Please note all abnormal findings. Check "□" indicates normal.

HEENT _____ Musculoskeletal/Back _____

Neck _____ Genitalia _____

Lungs _____ Neurologic _____

Heart _____ Skin _____

Abdomen _____ Prostheses? _____

Comments: _____

Describe any recent admissions or serious illnesses: _____

List of surgeries: _____

Mobility (e.g. wheelchair, crutches, amputation): _____

Special medical needs/care requirements (vision/hearing loss): _____

Is the child incontinent? ❑ Yes ❑ No **If Yes:** ❑ Bladder ❑ Bowel Is catherization needed? ❑ Yes ❑ No

❽ PSYCHOLOGICAL EXAMINATION

Has the patient been under the care of a psychiatrist? ❑ Yes ❑ No Please describe any behavioral, social, emotional, or psychiatric issues that may affect the child: _____

Is the child on an Individualized Education Plan (IEP? ❑ Yes ❑ No

❾ LABORATORY INVESTIGATIONS

Date: _____ H/H _____/_____ WBC _____(ANC _____) Platelets _____

Chemistries: _____ Urinalysis:_____

Will the child require laboratory tests while at camp? If so, please specify which tests and to whom results should be mailed/faxed. (Please limit these to essential studies.) _____

❿ MEDICATIONS*

WITH THE EXCEPTION OF WEEKLY METHOTREXATE, CHEMOTHERAPY IS NOT ADMINISTERED AT CAMP.

Please list medications that the camper receives routinely (include pain management). Attach additional pages if necessary.

Medication	Dose	Route	Frequency

*Each family should bring all medications, dressings, and other supplies necessary for their child while at camp.

☞ **IS THERE ANYTHING ELSE WE SHOULD KNOW THAT WOULD BETTER ASSIST US IN PREPARING FOR THIS FAMILY TO ATTEND CAMP? IN PARTICULAR, ARE THERE ANY SOCIAL OR EMOTIONAL CONCERNS PERTAINING TO ANY FAMILY MEMBER?** _____

_____

_____

_____

_____

The child's next appointment is due: _____

We regret that applications cannot be reviewed unless the signature of the attending physician or certified nurse practitioner is provided below. Thank you.

I have examined _____ **who is physically able to engage in camp activities except for the limitations and restrictions noted above.**

Attending physician/nurse practitioner's signature: _____ **Date** ____/____/____

Type/print name: _____

Address: _____

Telephone: (____) _____ **Fax: (____)** _____

Telephone or pager where a physician who is familiar with child can be contacted at night and on weekends: (_____)

_____

☞ **PLEASE NOTIFY US OF ANY UPDATES (I.E., MEDICATIONS, LAB RESULTS) WE SHOULD BE AWARE OF** ☜

Camp Sunshine: 35 Acadia Road, Casco, Maine 04015 P: (207) 655-3800 F: (207) 655-3825