NEVADA CHAPTER
NATIONAL HEMOPHILIA FOUNDATION
for all bleeding and clotting disorders

CAMP PHYSICAL

To the Physician: Your cooperation is needed in supplying the pertinent information about this applicant for attendance at Teen Rafting Camp. We will have Registered Nurses familiar with bleeding disorders on staff that will assist any camper with medical needs. All information is confidential and solely for the guidance of the camp's staff.

Child Name: _____DOB_____

Any and All of Child's Medical Diagnosis:_____

Date of diagnosis:_____

Last course of treatment: _____Date:_____

Date therapy discontinued: _____ Drugs administered:_____

Describe any recent operations or serious illness: _____

Does child require treatment? _____ Describe any physical disability and/or physical limitations involving any camp activity:_____

_____

Should this child be allowed to swim in the camp pond?: Yes No

Convulsions/Seizures (type & frequency):

_____

Allergies (including foods, medications):_____

Impaired hearing:_____ Impaired vision: _____

Neurological Deficit/Muscular Problems:

_____

Cardiac Abnormalities (i.e. abnormal echo cardiogram):

_____

Blood Pressure: _____

PHYSICAL EXAM

HEENT	N	ABN_____	Skin	N	ABN_____
Chest	N	ABN_____	Extremities	N	ABN_____
ABD	N	ABN_____	Cardiac	N	ABN_____
Neuro	N	ABN_____	_____		

Immunizations: Up to date? YES NO (If no, explain) _____

Date of last tetanus shot: _____

Recent surgery or illness: YES NO (If yes, please describe)_____

Other Medical DX: _____

Recent contact with a contagious disease? YES NO (If yes, please describe)_____

Physician's notes/special instructions:

NEVADA CHAPTER
NATIONAL HEMOPHILIA FOUNDATION
for all bleeding and clotting disorders

CAMP PHYSICAL

Date:	**Most recent Blood Count taken within four weeks of Camp:**	**Date:**	**Most recent Blood Count taken within four weeks of Camp:**
H/H:		PLATELETTS:	
WBC:		EOS:	
DIFF:		MONOS:	
SEGS:		Other Significant Laboratory Abnormalities:	
BANDS:			

MEDICATIONS: (to be completed by parent/guardian and reviewed by physician)

If your child requires medication at camp, please complete the following.

Parent/Guardian please send all meds to be taken during camp operating hours. Please send in pre-labeled bottles clearly marked with child's name, drug name, dose amount and when to be taken. At check in (drop off location), sign all meds in with medical staff. The camp medical staff will receive, store and administer the drugs as directed.

DO NOT SEND MEDS WITH CHILD IN CHILD'S BACKPACK.

List medications needed at camp:

Drug Name	**Dose**	**Frequency**

Describe pattern your child prefers while receiving medication:

Physician's Statement:

I have examined _____ who is physically able to engage in camp activities, except for physical limitations and restrictions listed above. I hereby verify the information concerning health matters, drugs and immunizations.

Physician's Name (**PRINT**): _____

Physician's Signature:_____ Date: _____

Hospital/Doctor Office Affiliation: _____

Office Phone Number: _____ Off Hours on Call: _____

NEVADA CHAPTER
NATIONAL HEMOPHILIA FOUNDATION
for all bleeding and clotting disorders

CAMP PHYSICAL

Physician Please Complete Below Only if Camper Has a Bleeding Disorder

Child Name _____

HEMOPHILIA: (circle) A or B Severe Moderate Mild Carrier VIII _____% IX _____% History of Inhibitor Yes No Last Inhibitor Test _____BU
Date _____

Von WILLEBRAND DISEASE :(circle) Type 1 2A 2B 2N 2M 3 Unknown
Levels: VIIIC_____% Rcof _____

OTHER COAG DX: _____

TREATMENT PRODUCTS: for bleeding or prevention.
Concentrate used (brand) _____Routine dose _____
Units or _____U/kg

Does Camper Self-Infuse? (circle) Yes No Needs Help

Does Camper use EMLA prior to infusing? (circle) Yes No

DDAVP/STIMATE Used? (circle) Yes No IV SQ Intranasal

AMICAR Used? (circle) Yes No _____

PROBLEM JOINTS: (Explain) _____

INSTRUCTIONS:
Treat only "as needed" while at camp? Yes No

Give Prophylaxis treatment at camp in addition to other treatments as needed? Yes No

Prophylaxis dose _____units on: (circle) Tues. Wed. Thurs. Fri. Sat.

Other Instructions: _____

CENTRAL LINE: (if present) Type: (circle) Port-a-cath or Broviac/Hickman

Catheter care: How often is it flushed? _____ with what products/how much? _____

When is dressing changed? _____

When is cap changed? _____

May child go swimming? Yes No
Instructions (including before & after swimming): _____

Physician's Special Instructions/Notes: _____

_____

Physician's Signature _____ **Date** _____