CAMPER'S MEDICAL FORM

The treating oncologist or pediatrician should complete this form.
Please print or type.

Camp Rising Sun

538 Preston Avenue
PO Box 1004
Meriden, CT 06450
(203) 379-4700
1-800-492-7161
FAX:203-379-5060

Camper's Name _____ Male/Female

Date of Physical _____ Birth Date _____

Height _____ Weight _____

CANCER DIAGNOSIS & TREATMENT INFORMATION

Diagnosis _____ Date of Diagnosis _____

☐ On Therapy ☐ Off Therapy Present Course of Treatment _____

Date of Most Recent Treatment _____ How Long In Remission? _____

Most Recent Blood Counts (CBC and Differential)

Date	Platelets	If child is receiving chemotherapy, counts should be taken within four weeks of camp. Please remind parents to bring the most recent counts to camp if they are not recorded on this form.
Hemoglobin	WBC	
Hematocrit	ANC (absolute neutrophil count)	

Does the camper have a central line or any other indwelling catheter?

Days line is usually flushed _____ Any difficulty with line _____

Amount and concentration of heparin used

Please describe any recent operations or serious illness the child has experienced, and any observations and/or treatment that may be required.

GENERAL HEALTH INFORMATION

Please describe, if appropriate:

Neurological problems, i.e., seizures	Cardiac problems	Respiratory problems
Genitourinary problems	Muscular problems	Gastrointestinal problems
Vision problems	Hearing problems	Skin problems or rashes
Allergies (including foods, medications, insect stings, and hay fever)		

Restrictions: Diet? Swimming or Water Sports?

Climbing? Contact Sports?

Strenuous Activity? Special Equipment (Glasses, Prosthesis, Crutches)

PHYSICIAN'S ORDER

Medications needed in camp? ☐ Yes ☐ No Condition(s) for which medication(s) are being administered:

Medication	Dosage	Time Taken

Comments:

I have examined the above named person on _____(date of examination) and have determined that he/she is in satisfactory condition to engage in all camp activities with these restrictions, limitations (including diet) or recommendations:

Physician's Signature Date

Address City, State, Zip

Phone ( ) State of Licensure

MEDICATIONS MUST BE BROUGHT IN THEIR ORIGINAL PHARMACY CONTAINERS.

Please return this completed Medical Form, with the Camper's Application, to:

Camp Rising Sun, 538 Preston Avenue, PO Box 1004, Meriden, CT 06450

Parent Consent – To be signed by Parent at Camp during Check-In

I give my consent for the Camp Rising Sun Medical staff to dispense the above prescribed medications to my child.

Parent's Signature _____ Date _____

Parent's Name – Printed _____