Camper Health Evaluation

Please print, complete, return this form at least ONE month before camp.

SANFORD Children's

TO BE COMPLETED BY MEDICAL PROVIDER:

Name of Camper: _____

Date of Exam _____ (must be within 6 months of camp) Age: _____

Participation level at camp: Full Participation or Limited Participation (circle one)

Activity Restrictions: _____

Height: _____ Weight: _____ Blood Pressure: _____

The applicant (camper) is under the care of a physician for the following condition(s): _____

_____

_____

Current treatment (protocol) at the time of this report: _____

_____

_____

Date of last treatment: _____ Treatment to continue at camp: _____

What treatment/chemotherapy was given: _____

Central line: Yes or No (circle one) If yes, Broviac (external) or Port (internal) (circle one)

Will it need to be flushed the week of camp? Yes or No (circle one) If yes, how often: _____

Type of dressing for central line and does it need to be changed at camp:_____

_____

Any medically prescribed meal plan or dietary restrictions: _____

_____.

Any allergies (food, drug, plants, insects, etc.): _____

Any additional health information: _____

_____

Signature of Licensed Medical Personnel: _____

Printed Name: _____ Title: _____

Address: _____ Phone No._____

Date form completed: _____ By: _____ (initial if done on behalf of physician)

Fax to: (605) 328 - 1514 or

Mail to: Camp Bring it On, Route #6374, 1305 W. 18th St., PO Box 5039, Sioux Falls, SD 57117-5039