Camp Heart Connection – Camper Health Evaluation

ALL forms, for both Oncology Camp and Sibling Camp, are due by ***May 15th.***

I have examined (name): _____ Date last examined: _____ DOB: _____ Age: _____
Last First **(Must be within the last 12 months)**

In my opinion, the child **should should not (circle one)** participate in an active camp program, with the exception of the following restrictions:

_____

_____

Varicella vaccine date: _____ Varicella disease date: _____

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

_____

_____

Current treatment (protocol) at time of this report (including all prescription and over-the-counter medications): _____

_____

_____

Explanation of any reported loss of consciousness, convulsions, or concussions: _____

_____

Allergies:

_____

Height: _____ Weight: _____ lbs / kg Temp: _____ Pulse: _____ Resp: _____ Blood Pressure: _____ Date: _____

Exam Findings	Normal	Abnormal
1. Appearance		
2. Eyes/Ears/Nose/Throat		
3. Mouth & Teeth		
4. Neck		
5. Lymph Nodes		
6. Heart		
7. Pulses		
8. Chest & Lungs		
9. Abdomen		
10. Skin		
11. Musculoskeletal – ROM		
12. Neurological		

Comments regarding abnormal findings: _____

_____

Recommendations and Restrictions while at Camp: _____

_____

Additional activities to be encouraged or limited: _____

_____

Additional health information: _____

_____

Signature of Licensed Medical Personnel: _____

Printed Name: _____

Title: _____

Address: _____
Number & Street City Zip

Phone: (_____) _____ Fax: (_____) _____

Date Form Completed: _____ *By: _____
*initial if completing this form on physician's behalf
(Must be nurse or physician's assistant)

Mail to: Children's Cancer Connection - Camp Application
2708 Grand Avenue | Des Moines, IA 50312-5218
OR Fax: (888) 279-5528 | Email: Camp@ChildrensCancerConnection.org | Call: 515-243-6239