This form is to be completed by a Licensed Health-Care Practitioner

CAMP HONOR – CAMPER MEDICAL FORM 2020

Name _____ DOB _____
Last First Middle Initial

I have examined the above participant. Date of last examination _____

Weight _____ BP _____/_____ Pulse _____

MEDICAL CONDITIONS

Heart Disease ____ Kidney Disease ____ Asthma ____ Seizures ____ Hemophilia or VWD ____ HIV ____ Diabetes ____

Other:_____

Allergies: _____

Any recent significant illnesses, injuries, infections or hospitalizations: _____

_____

—PHYSICIANS Complete This Box For Campers With Bleeding Disorders—

Type of Bleeding Disorder: □VIII □IX □VWD □Other _____ Level/Severity _____

Current Transfusion Product _____

Life-threatening Bleeds _____Units Major Bleeds _____Units Minor Bleeds _____Units

Home Infusion? ____Yes ____No Describe any Target Joints _____

Inhibitor? ____No ____Yes – If yes, Last Titer and date _____ Immune Tolerance ____No ____Yes

Prophylaxis? ____No ____Yes – If Yes Dose and Schedule _____

Central Line? ____No ____Yes – If Yes What Type? _____

Hepatitis B Antigen ____Pos ____Neg Hepatitis B Surface Antibody ____Pos ___Neg Hepatitis C ____Pos ____Neg

PHYSICAL EXAM

GENERAL	NORMAL	ABNORMAL	EXPLAIN ABNORMALITIES
Head & Neck	_____	_____	_____
Eyes & Ears	_____	_____	_____
Nose & Throat	_____	_____	_____
Chest	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Skin	_____	_____	_____
Lymphatic	_____	_____	_____
Neurological	_____	_____	_____
Joints/Muscles	_____	_____	_____

Name _____ DOB _____
Last First Middle Initial

Assessment and/or any other significant medical history/psychosocial history:

_____

_____

_____

Limitations

Activity restrictions _____

Diet restrictions _____

Immunizations Please attach immunization record

MEDICATIONS

Please list All medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person takes NO medications on a routine basis.

List Medications

Drug Name	Dose	Schedule	Reason for Taking

In my opinion, the above applicant ☐ is ☐ is not able to participate in an active camp program.

Signature of Provider _____ **Date**_____ **Phone** _____

Printed Name _____ **Mailing address** _____

Return to: Arizona Bleeding Disorders
826 N 5th Ave
Phoenix, AZ 85003

Fax: 602-955-1962