Physical Exam Form

Date Received: _____
(for office use only)

IMPORTANT!
Participant (or parent/guardian for participants under age 18) should complete and sign the top section of this form, authorizing the release and transmission of medical information to Camp Mak-A-Dream. Form must then be completed by the participant's physician and returned to Camp Mak-A-Dream as soon as possible. Applications will not be considered until both the Participant Application and Physical Exam Forms have been received by Camp Mak-A-Dream.

NAME / CAMP SESSION Participant Name: _____

Camp session participant is applying for:_____ Date: _____

(See Program Schedule at www.campdream.org for list of sessions, dates and ages)

I give permission for my/my child's physician(s) to provide medical information directly to Camp Mak-A-Dream.

X_____ _____
Participant / Parent-Guardian Signature *Date*

Storage and administration of medications will be provided for all participants under the age of 18. If you are over 18, do you need us to assist you in administering your medications? Yes ❑ No ❑

Physicians are to complete the remaining portion of the form and return to:
Camp Mak-A-Dream / P.O. Box 1450 / Missoula, MT 59806-1450 / Fax: (406) 549-5933

MEDICAL DIAGNOSIS
Participant Name: _____ Date of Diagnosis: _____

Type of Diagnosis: _____ Primary Site: _____

Other involvement site(s): _____

Treated with (check all that apply): ❑ Chemotherapy ❑ Radiation ❑ Surgery ❑ Other_____

List relevant surgeries and dates: _____

_____

Has participant completed therapy? Yes ❑ No ❑
If yes, date of most recent treatment:_____ Type of treatment: _____
If no, in the month prior to camp, will participant receive Chemo? Yes ❑ No ❑ Radiation? Yes ❑ No ❑
If treatment or medications are to be administered at camp, please note instructions on next page.

Are participant's immunizations up to date? Yes ❑ No ❑ If no, please explain:_____
Describe any special condition(s) or care needed while at camp:_____

Describe any physical disabilities, limitations or restrictions:_____
_____

HT: _____ WT: _____ EENT: _____
LYMPH:_____ LUNGS: _____ GU: _____
HEART: _____ ABD:_____ EXT: _____

Other significant findings:_____

MEDICATIONS
List all medications currently being taken by participant (attach additional list if needed).

Participants should bring all medications (in their original pharmaceutical bottles), including Chemotherapy, catheter dressings and any other supplies needed during Camp with them.

ORAL MEDICATIONS

Drug Name and Strength	*Dose*	*Frequency*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV, IM or SQ MEDICATIONS

Drug Name and Strength	*Dose*	*Route*	*Frequency*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ADDITIONAL INFORMATION
List any laboratory studies or treatments to be done (with dates) while participant is at camp. Include any special instructions and information about medications used to prevent nausea, vomiting and pain management:
_____

_____

Where are results to be called/sent?_____

MOST RECENT BLOOD COUNT

Please attach a copy of participant's most recent lab results report. For anyone currently undergoing treatment, these labs should be done within 30 days of the participant's arrival at Camp.

List any significant laboratory abnormalities:_____
List any specific restrictions, limitations or suggestions for this participant while at camp:_____

_____

DOCTORS STATEMENT
I have examined _____ who is physically able to engage in camp activities, except for those physical limitations and restrictions listed above.

X _____ _____ _____
Physician Signature Typed or Printed Name Date