Participant's Name: _____**DOB:** _____

Camp you are attending: _____

Participant Physical Form

The following form must be filled out and signed by the participant's physician and returned to Camp Mak-A-Dream at least 45 days prior to camp.

MEDICAL DIAGNOSIS:

Date of Diagnosis: _____Type of Diagnosis: _____

Primary Site: _____ Other involvement site(s):_____

Is participant currently in treatment?

☐ **NO** (complete this box)

Has camper completed therapy?
Yes ___ No ____

Date of most recent treatment:
_____

Type/name of treatment:
_____

☐ **YES** (complete this box)

On active chemotherapy? Yes ____No___
On maintenance therapy? Yes ____ No ___

Type of chemotherapy:
Pills ____ IV _____Other _____
What agent(s)?
_____

In the month prior to camp, will camper receive:
Chemo? Yes ___ No ___
Radiation? Yes ___ No___

Is severe bone marrow suppression expected? If so when? What are the participant's transfusion thresholds? _____
_____
_____

Have blood transfusions been needed? Last transfusion? _____

With the exception of oral chemotherapy, chemotherapy is not administered at camp.

** ***If camper has been in treatment in the last 12 months:*** *Please attach a copy of most recent lab results. For anyone currently undergoing treatment, these labs should be done within 30 days of arrival at Camp.*

Post Bone Marrow Transplant? Yes ____ No ____ Date: _____

IF YES: Does the participant have Graft vs Host Disease (GVHD): No_____ Yes_____

Current GVHD symptoms_____

If participant gets a temperature above _____ does he/she require blood work and/or antibiotics? Which antibiotics?
Yes ____ No ____ please explain: _____
_____
_____

Allergies: _____

Type of Reaction: _____

Will participant be bringing Epi-Pen? Yes_____ No_____

Participant's Name: _____**DOB:** _____

Camp you are attending: _____

Participant Physical Form

PHYSICAL EXAM: Date of physical _____

Must have been completed within last 12 mos

Code: Satisfactory (X) Not Satisfactory (O) Not Examined (-)

HT: _____ WT: _____ HEENT: _____
LYMPH:_____ LUNGS: _____ NEURO: _____
HEART: _____ ABD:_____ EXT: _____
Are Immunizations up to date (i.e. age-appropriate vaccinations including MMR, DTaP or Tdap, COVID, Varicella or titer test?) Yes: _____ No (Please explain): _____
_____

ADDITIONAL INFORMATION

- Abnormal physical exam findings: _____
- Other medical conditions: _____
  _____
  _____
- Relevant surgeries and dates within the last 12 months: _____
  _____
- Does the participant have a shunt? Yes ___ No ___. Is shunt functioning? Yes ____ No ____
- Does the participant have seizures? Yes ____ No ____
  IF Yes: Please further explain nature of seizures.
  Type and frequency? _____
  Date of last seizure? _____
  Emergency seizure medication/s camper will be bringing and instructions for administration:
  _____
- Do participant require any other additional emergency medications (please explain)?
  _____
- List any labs to be done (with dates) while participant is at camp. _____
  _____
  Fax number for results: _____
- Are there specific restrictions, activity limitations or suggestions for this participant while at camp? Yes____ No____ If yes, please explain: _____

_____
_____

Please attach a copy of your active medication list for camper. If IV medications are necessary during camp call the Camp office at (406) 549-5987

PRACTITIONER'S STATEMENT

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

X _____ _____ _____
Provider's Signature Typed or Printed Name Date

Provider contact phone: _____

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