SANFORD Children's

Camper Health Evaluation

Please print this form and return it by May 17th. Please contact your physician to schedule an appointment.

TO BE COMPLETED BY MEDICAL PROVIDER

I have examined (name of camper): ____________________

Date of exam: ____________ (must be within 6 months of camp) Age: ________

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

Activity restrictions: ____________________

Height: __________ Weight: __________ Blood pressure: __________

The applicant 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 No (circle one) If yes, Broviac (external) or port (internal) (circle one)

Will it need to be flushed the week of camp? ❑ Yes ❑ No 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#: __________

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

Return this form by: May 17th, 2020

Fax to: (605) 328-1514 or
Mail to: Camp Bring-It-On Wendy Jensen, Route # 6374 1305 W 18th Street, PO Box 5039 Sioux Falls, SD 57117-5039
Call (605) 328-7157 for more information.

012000-00871 Rev. 3/20

Medication during camp: Medications are dispensed at each meal and at bedtime. We would prefer to give as many evening medications as possible with supper. If the evening medications must be given at bedtime, please indicate this below.

Name of Medication	Route *(Mouth, IV, SQ, etc.)*	Dosages	Frequency *(include even/odd days)*	Circle the time of day to be given
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
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