Kay's Kamp

Physician/PNP Recommendations and Restrictions at Kamp

THIS PAGE TO BE COMPLETED BY PHYSICIAN OR PNP
(Fax to: 302-836-8534)

I examined ______________________________(DOB)__________________ **on** ___________________
Kamper's Full Name — Date of Most Recent Examination

Original Diagnosis _____________________**on** __________ **Facility Treating**______________________

Weight: _________ Height: _________ BMI: __________ BP: _______ HR: _______ RR: _______

Last blood count: Date: ______________ Hgb ____________ Hct ____________ WBC ____________
Platelets _________________ ANC __________________ Varicella Titer ________________________

Date of Bone Marrow Transplant/Stem Cell Transplant _____________

Date of last Chemotherapy _____________________Radiation ______________________

Current physical and medical condition: X=within normal limits O=see remarks below

____ scalp, skin	____ heart	____ vision	____ ear, nose	____ lungs
____ hearing	____ throat	____ abdomen	____ neck	____ eyes
____ genitalia	____ teeth	____ extremities	____ lymph nodes	____ nervous system

REMARKS: ____
____
____

Current Chemotherapy: Please include a copy of current chemotherapy roadmap or regimen.
____
____

I have read Kay's Kamp policies regarding CVL's and water sports/activities. ***Yes*** ***No***
(Available online at: kayskamp.org/applications.htm)

Description of any limitation, concern or restriction on Kamp activities:
____
____

Any medically prescribed meal plan or dietary restrictions:
____
____

I hereby verify that the information on the above form and preceding forms containing health matters and medications are correct. In my opinion, this child is able to participate in Kay's Kamp Summer Kamp.

Signature of Physician/Practitioner _____________________________________
Print Name _______________________________ Date _________________________
Phone ____