

Camper Health Evaluation

Please print this form and return it by May 22nd. 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 22, 2020

Fax to: (605) 328-1514 or

Mail to: Camp Bring-It-On Tristan Hargens, Route # 6374, 1305 W 18th Street, PO Box 5039 Sioux Falls, SD 57117-5039

Online Upload: sanfordhealth.org (keyword: Sanford Camps)

