Camper Medical Provider Form
Camp Korey Family Weekend Application

This form should be filled out *only for the child/children between the ages of 5 and 16 who are living with the condition we are serving for the Family Weekend*. Please note: if your child was a camper in one of Camp Korey's summer 2015 camp sessions, and there have been no significant changes to his/her health, then you do not need to fill out this portion of the application.

This form must be completed and signed by the child's health care provider (Physician, Nurse Practitioner, or Physician's Assistant). Please be as detailed a possible and answer all questions. Please include a copy of the child's most recent discharge summary and clinic letter. If the child routinely has lab work, please attach most recent lab results. Please fax completed form to 425 844 3171 or scan/email to camperrecruiter@campkorey.org.

Today's date:_____ **Camper name**:_____ **Date of birth**: _____

Primary diagnosis:_____

Other diagnoses:_____

Drug allergies: _____

Other allergies (please specify):_____

VS: Ht (inch/cm) _____Wt (lb/kg)_____ BP_____ HR _____RR_____

Does this child have any of the following?

☐Central venous line/ Port-a-cath; Type _____; Location _____
☐Tracheostomy; Type/ Size _____; Date of last change_____

☐CPAP	☐Malone/ ACE	☐Bile Tube	☐Central Access	☐Insulin Pump
☐BiPAP	☐G-Tube	☐Ostomy	☐Hearing Aids	☐Urinary Diversion (Mitrofanoff)
☐Oxygen	☐NG-Tube	☐J-Pouch	☐Glasses/ Contacts	☐VP Shunt
☐PE Tubes	☐Feeding Tube			

*If child has any of above, camp medical providers may contact you for additional information

Does this child have:

☐Yes ☐No Any activity restrictions?
☐Yes ☐No An increased risk for injury from trauma?
☐Yes ☐No A known osteoporosis or past history of multiple fractures?
☐Yes ☐No A known risk for bleeding?
☐Yes ☐No Any special mobility needs (i.e. wheelchair, walker, braces, etc.)?
If yes to any of the above, please explain: _____

_____

_____

Physical Examination (check box if normal results, or give details of abnormalities below)

☐ Head: _____
☐ Eyes: _____
☐ Ears: _____
☐ Nose/Mouth: _____
☐ Teeth: _____
☐ Neck: _____
☐ Chest: _____
☐ Heart: _____
☐ Abdomen: _____
☐ Genitalia/rectum: _____
☐ Neurological: _____
☐ Musculoskeletal: _____
☐ Skin: _____
☐ Back: _____

Please list any major surgeries: _____

_____

Please list and explain any hospitalizations in the last 6 months: _____

_____

Is this child developmentally appropriate for his/her age? ☐Yes ☐No
If no, at what age does this child function? _____

Is this child on Coumadin/Aspirin/Lovenox or other antiplatelet therapy? ☐Yes ☐No
If yes, please list drug and dose: _____

Is this child on immunosuppressive medications? ☐Yes ☐No
If yes, please list drug and dose: _____

Does this child have lapsed or incomplete immunizations? ☐Yes ☐No
If yes, please explain: _____

Does this person have live vaccines deferred? ☐Yes ☐No
If yes, please explain: _____

Has this child had clinic evidence of chickenpox or shingles? ☐Yes ☐No
If yes, when? _____

Does this child have any TB risk factors? ☐Yes ☐No
If yes, explain results of screening: _____

Does this child have a history of MRSA infection? ☐Yes ☐No
If yes, list date and explain treatment: _____

Does this child have a history of VRE infection? ☐Yes ☐No
If yes, list date and explain treatment: _____

Please list any current medications, or attach a separate medication sheet.

_____

_____

_____

_____

_____

_____

_____

_____

Please give any additional details that you feel will help us care for your patient (special diets, behavioral issues, routine procedures, medical or social background, etc.).

_____

_____

_____

_____

_____

Clinic name: _____ **Hospital affiliation**: _____

Phone number: _____ **Fax number**: _____

Emergency/on-call phone: _____ **Email**: _____

Physician/NP/PA name (please print): _____

Physician/NP/PA signature: _____

If a nurse assisted with completing this form, please read and sign below.
As the RN working with _____ ☐MD☐NP☐PA, I have reviewed the camper's medical information and this Camper Medical Provider Form with the child's physician/NP/PA.
RN name: _____ **RN signature**: _____

Thank you for completing the Camper Medical Provider Form for this child's application to attend Camp Korey's programs. Please fax completed form to 425 844 3171 or scan/email to camperrecruiter@campkorey.org. For application-related questions/concerns, please contact the Camper Recruiter, Shivani Gogna, at 425 844 3226.

If you have any medical questions or concerns, please contact:
Nicki Broas, ARNP
Nursing Director, Camp Korey
nbroas@campkorey.org
425-844-3129