



A program of The ELM Project

This packet is to be filled out by a health care provider

Camper Medical Application 2024
Children with Sickle Cell & Siblings

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Today's Date: Session Date: Sunday, August 18th – Saturday, August 24th

Child's Name: Age: Date of Birth:

Sex: Male Female Other If other, please describe:

Copy of Insurance Card MUST BE ATTACHED

Some of the below questions are specific to children with sickle cell disease. For siblings of children with sickle cell, please skip to page 2 and provide all relevant information.

Sickle cell Type: HbSS HbSC HbS beta0 thal HbS beta+ thal Other

Has the child EVER been hospitalized for any the following conditions?

- VOC/pain crisis Acute Chest Syndrome Stroke
Priapism Sepsis Gallstones/Cholecystitis
Avascular Necrosis Liver problems Kidney problems
Sleep apnea Splenic sequestration

Date of last admission for VOC:

Describe the child's typical VOC episodes:

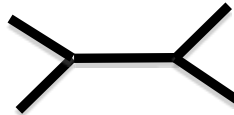
Treatment plan when a pain crisis does occur:
(Medications & dose e.g., NSAIDS and/or opioids)

Is the child on a chronic transfusion protocol? Yes No

Frequency of transfusions: Date of last transfusion be prior to camp:

(Please consider a transfusion the week prior to camp to allow for maximum camp experience)

Child's baseline CBC: Date:



MEDICAL EQUIPMENT:

Does the child use any special medical equipment (i.e., Home Oxygen, PICC line, Feeding Tube, etc.)?

If yes, please describe:

To be completed for ALL campers...

UNDERLYING MEDICAL CONDITION(S):

Primary diagnosis: _____ Any secondary diagnosis: _____

BEHAVIORAL AND MENTAL HEALTH HISTORY (INCLUDING ADHD, AUTISM SPECTRUM DISORDER, ETC):

PAST SURGICAL HISTORY: _____

Has child been hospitalized in the past year? Yes No If yes, why? (Include psychiatric): _____

ALLERGIES: Food Allergies: _____ Medication Allergies: _____
Seasonal Allergies: Yes No Other: _____

Special nutritional requirements: _____

Restricted Activities: _____

Any additional comments: _____

IMMUNIZATIONS: Please attach copy of up-to-date immunization records (including COVID vaccination)

****IF WE DO NOT RECEIVE IMMUNIZATION RECORDS, CHILD MAY NOT ATTEND CAMP****

Is the child exempt from immunizations? Yes No If yes, please explain: _____

PHYSICAL EXAM: (May attach a recent H&P in lieu of completing the following section)

Most recent vitals: BP: _____ HR: _____ RR: _____ O2 Sat _____

Please check box if exam was normal on the following:

- | | | | |
|---|-------------------------------------|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Psychosocial development | <input type="checkbox"/> Behavioral | <input type="checkbox"/> HEENT | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Lung | <input type="checkbox"/> CVS | <input type="checkbox"/> Abdomen |
| <input type="checkbox"/> Extremities/MSK. | <input type="checkbox"/> Skin | <input type="checkbox"/> Neurological | <input type="checkbox"/> Back/spine |

Any abnormal findings: _____

HEALTH CARE PROVIDER INFORMATION

I have examined _____ and find them to be physically able to attend Camp AmeriKids. I understand the attached medical regimen will be followed while the child is at camp (unless otherwise indicated on a "late changes" form).

Signature: _____ Name (print): _____ Date: _____

Phone#: _____ Office: _____ Beeper: _____

Emergency: _____ Address: _____

Health Care Provider stamp:



To be filled out by child's
health care provider

MEDICATION LIST

(Including prescription and over the counter medications)

IMPORTANT: Please verify that the camper has an adequate supply of all prescribed medications, including opioids, for the entire camp duration. Campers lacking an adequate supply of medications will not be allowed to attend camp, no exceptions.

Child's Name: _____

DOB: _____

Prescription and over the counter medications to be given at Camp:

None Required

Drug Name	Route	Dosage and Schedule	Indications	Comments

Additional Instructions: (As deemed necessary by health care provider to be implemented by RN)

After hours contact number in case of emergency: _____

Health Care Provider's Name: _____

Phone #: _____

Address: _____

License #: _____

Signature: _____

Date: _____