CAMP AMERIKIDS®
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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Phone (203) 658-9577 • Fax (203) 658-9615

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 β0 thal ❑ HbS β+ thal ❑Other_____

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

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

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:

❑ Psychosocial development	❑ Behavioral	❑ HEENT	❑ Neck
❑ Dental	❑ Lung	❑ CVS	❑ Abdomen
❑ Extremities/MSK.	❑ Skin	❑ Neurological	❑ 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: _____