

RONALD MCDONALD CAMP 2022

Camp Dates: August 14-20

CAMPER PATIENT PHYSICAL

Please have this form completed by a physician/nurse practitioner and returned by the application deadline of May 15. On-therapy patient campers must have a physical exam within 6 months, and off-therapy patients within 12 months of attending camp. Thank You!

Patient's Name: _____ Date: _____

MEDICAL DIAGNOSIS _____

Date of diagnosis: _____ Current Therapy: _____

Date & type of most recent chemotherapy (last six months): _____

Is it possible that your patient will be receiving chemotherapy within 2 weeks of camp?

Yes _____ No _____

**All on-therapy campers will be required to have a CBC done within a week of camp and campers with expected prolonged count suppression of thrombocytopenia requiring transfusions may not be eligible for camp. The camp medical staff will make the final decision regarding eligibility the week before camp.

Date off therapy: _____

Date and site of last radiation therapy: _____

Date and site of previous surgeries: _____

Describe any physical/cognitive challenges and/or physical limitations/restrictions to activity (include crutches, wheelchair, prosthesis): _____

Describe any allergies (type, reaction and management of reaction): _____

_____ **CAMPER TAKES NO MEDICATION ON A DAILY BASIS**

ORAL MEDICATION

Drug Name & Strength	Dosage	Frequency	Reason for Taking

SUBCUTANEOUS(SQ)OR INTRAMUSCULAR (IM) INJECTION

Drug Name & Strength	Dosage	Route	Frequency	Reason

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PHYSICAL EXAMINATION Please have your child's physician/nurse practitioner fill this section out completely. It is required that all on-therapy patient campers have **physical exams within 6 months** of attending camp. Off-therapy patients must have a physical exam within **12 months** of attending camp.

PATIENTS NAME _____ DOB ____/____/____

Date of Exam: ____/____/____ Height: _____ Weight: _____

Blood Pressure: _____ Heart Rate: _____ Respiratory Rate: _____

System	Normal	Abnormal/Please explain
General		
HEENT		
Neck		
Lungs		
Heart		
Abdomen		
Neuro		
Skin		
GU		
Musculoskeletal		

Central Line: Y N. If Yes, type: _____

Other Comments: _____

Doctor's/Nurse Practitioner's Statement: The patient above is physically able to engage in camp activities, except for physical limitations and restrictions listed above.

NP/ MD Signature _____ Date: _____

Print Name _____

Address: _____

Phone: _____

Parents: You have 2 options to return this form:

- 1. Scan and upload to your child's application paperwork.***
- 2. Email to camp@rmhcphilly.org***