RONALD MCDONALD CAMP 2025

CAMP DATES: AUGUST 17-23

PATIENT PHYSICAL

Please have this form completed by a physician/nurse practitioner and returned by the application deadline of May 1. On-therapy patients 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 camper 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 those 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/any restrictions to activity

(include crutches, wheelchair, prosthesis):_____

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

_____

CHECK HERE IF YOUR CHILD 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

RMC 2025 PATIENT PHYSICAL

STRESS DOSE STEROID PLAN

Drug Name & Strength	Dosage	Route	Frequency	Reason

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

PATIENTS NAME_____ DOB _____/_____/_____

Date of Exam: _____/_____/_____ Height:_____ Weight:_____
Blood Pressure: _____ Heart Rate: _____

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

Central Line: Y/N. If Yes, type: _____
Shunt : Y/N. Shunt comments: _____
G-tube or NG Feeds: Y/N

Other Comments:_____

Doctor's/Nurse Practitioner's Statement: The patient above is physically able to engage in camp activities, including but not limited to lake, pool, high/low ropes course, and activities in a natural environment, except for physical/cognitive challenges and restrictions listed above.

NP/ MD Signature _____ **Date:** _____
Print Name _____
Address: _____
Phone: _____

You have 2 options to return this form:
1. Scan and upload to your application paperwork.
2. Email to camp@rmhcphilly.org