

Camp High Hopes - 2010

Camper Health Form – To Be Completed By Treatment Center or Provider.
Must Be Completed and Returned By July 4, 2010.

▪ Camper Name _____ Age _____
 Center/Provider _____ Date: _____

▪ Hemophilia A _____% Hemophilia B _____% vWfAg _____ Ristocetin Cofactor _____
 Date and result of last inhibitor _____
 Hepatitis status: HBsAg _____ HBsAb _____
 HepCAb _____ Total HepA Ab _____

▪ Any Allergies to medications including factor? _____

▪ Target joint(s)? _____ Specify joint(s) _____

▪ Is the child on any medications? (Indicate medication, dosage and schedule of administration.)

Medication	Dose	Route	Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

► **These OTC/PRN meds are stocked at camp. INDICATE ALL the camper may receive.**

<u>Drug name</u>	<u>Route</u>	<u>Dosage</u>	<u>Schedule/Indications</u>	<u>Can Be Given</u>		<u>Comments</u>
Tylenol	PO	per label instructions age/weight	every 4 hours PRN pain or fever	yes	no	
Ibuprophen	PO	per label instructions age/weight	every 4-6 hours PRN pain or fever	yes	no	
Robitussin	PO	per label instructions age/weight	every 4 hours PRN cough or congestion	yes	no	
Benadryl	PO	per label instructions age/weight	every 4 hours PRN itching or for allergy symptoms	yes	no	
Dimetapp	PO	per label instructions age/weight	every 6-8 hours PRN for nasal drainage or congestion	yes	no	
Loperamide	PO	per label instructions age/weight	as directed for loose stools	yes	no	

- Is this child on Prophylaxis? _____ Dose _____
- What days is the child treated? (Please circle) Mon. Tues Wed Thur Fri Sat Sun
- Does the child have? (Please circle) Infusaport Hickman
- What strength heparin flush is used? 10units/ml 100units/ml Other _____
- Do you have a protocol if child with venous access device has a fever? _____

► **Physical exam (must be done within three months of camp)**

P _____ BP _____ Ht _____ in/cm. Wt . _____ lbs/kg. Exam Date _____

Skin _____

HEENT _____

Lymph nodes _____

Chest _____

Heart _____

Abdomen _____

Neuro _____

Musculoskeletal _____

G.U. _____

► **Bleeding Episode Treatment:** specify brand of medication and dose to be given; these are our infusion orders for camp. Please attach most recent treatment protocol if you have one.

Major Bleeds (head, airway) _____

Joints _____

Soft Tissue _____

Renal _____

Nosebleeds _____

Doses for pre-medications if indicated _____

► **Is there anything else about this child you would like us to be aware of (including psychosocial):**

- Your daytime phone _____ Night/Weekends _____
- Signature _____ MD or NP
- Printed Name _____

Return this form by July 4 to: Camp High Hopes
 c/o Hope Woodcock R.N. – Health Director
 Box 11038
 Syracuse, NY 13208