Camp Quality USA, Inc. – Physical Exam Form

Physical Exam Form **(Cancer Patient)** - TO BE COMPLETED BY HEALTH CARE PROVIDER – *Information on this form is confidential.*

Camper's Name ____ DOB ____/____/______ Date of Exam ____/____/______

MEDICAL INFORMATION	
Primary Diagnosis:	Date of Diagnosis:
Past Medical History:	
On Treatment? ☐ Yes No ☐ If yes, date of last treatment: Type of Treatment (radiation, chemo, etc.)	
Off Treatment? ☐ Yes No ☐ If yes, date off treatment:	
Transplant: ☐ Yes No ☐ If yes, date: Type:	Graft vs. Host Disease: ☐ Yes No ☐
Do you expect the child to need chemo while at camp? ☐ Yes No ☐	Do you expect the child to need blood work while at camp? ☐ Yes No ☐
Allergies:	Any activity restrictions?
PLEASE ATTACH COPY OF IMMUNIZATION RECORDS	
Immunizations are: ☐ Up-to-date ☐ NOT up-to-date (MMR, DTap, Varicella)	
Covid-19 Immunizations are: ☐ Up-to-date ☐ NOT up-to-date	

OTHER RELEVANT SERVICES PROVIDING ACTIVE CARE:	
Surgery: ☐ Yes No ☐	Palliative Care: ☐ Yes No ☐
Orthopedics: ☐ Yes No ☐	Neuro Services: ☐ Yes No ☐
Endocrinology: ☐ Yes No ☐	Other: ☐ Yes No ☐

BASELINE VITAL SIGNS	LAB RESULTS
Temperature:	WBC:
Blood Pressure: /	ANC:
Pulse:	Hgb/Hct:
Respirations:	Platelet Count:
Height:	Additional Lab:
Weight:	Date of lab results:

BASELINE PHYSICAL EXAM. Please place a ☒ in the appropriate column. ***If abnormal, please describe below:***

NML	*ABNL		NML	*ABNL	
		HEENT			NEURO
		ABDOMEN			HEARING/VISION
		HEART			LUNG
		SKIN			MUSCULOSKELETAL

CENTRAL LINE – Unless otherwise specified, all children will be permitted to swim. *Dressings will be changed immediately following*
This child: ☐ DOES ☐ DOES NOT have a central line. Type:
This child: ☐ DOES ☐ DOES NOT have permission to swim in a chlorine-treated swimming pool. This child: ☐ DOES ☐ DOES NOT have permission to swim in a freshwater lake.

PHYSICIAN ACKNOWLEDGEMENT: I have been informed about Camp Quality and the request of my patient to attend. The items are correct to the best of my knowledge and belief. In my opinion this patient is physically and mentally capable of attending camp.

Provider's Signature		Date
Provider's Name (Please Print)		Phone
Hematologist/Oncologist Name		Phone
	Actively seeing Hematologist/Oncologist? ☐ YES ☐ NO	