The Valerie Fund's Camp Happy Times
Camper Medical Application (Part II)

2017 Dates: August 14th-20th Medical App Due: June 15th

Last Name: _____ First Name: _____

To Parent/Guardian:

Complete Sections I (Camper Information) and II (Treatment Center) below. Also include a photocopy of the front and back of your current health insurance card

Please schedule an appointment with your doctor as soon as possible to give him/her ample time to fill out this form which needs to be **returned by June 15, 2017**. If your child is not on active treatment, this application can be filled out by your primary physician. If circumstances or medications change after June 15th, please advise CHT (see medical contact information at the end of this form). If you have any general camp questions, please don't hesitate to email sspriggs@thevaleriefund.org or contact CHT Camp Director, Millie Finkel at milliesue@aol.com.

To Doctor:

Thank you for taking the time to complete the Camp Happy Times Medical Application. This portion is vital in the application process as it allows CHT to successfully prepare and plan for each camper. The following sections will provide the CHT medical staff and counselors with the necessary information required to provide the camper with any necessary medical care or address any special needs that may exist. If there are any concerns with the deadline or if you have any questions email sspriggs@thevaleriefund.org or milliesue@aol.com .

Please return this application by June 15, 2017.

I. Camper Information (must be completed by parent/guardian prior to doctor visit)

Camper Last Name	Camper First Name	Gender: ☐ Male ☐ Female	Date of Birth / /	Age

II. Treatment Center (to be completed by parent/guardian)

Name of Treatment Center:
☐ CHOP, Voorhees ☐ CHOP, Philadelphia ☐ Monmouth ☐ Morristown/Overlook ☐Newark Beth Israel
☐ NY Columbia Pres. ☐ St. Barnabas ☐ St. Joseph's ☐ St. Peter's ☐ Robert Wood ☐ Other_____

Name of Doctor at Treatment Center	Name of Social Worker	Center Phone	Center Fax

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III. Medical Information (to be completed by doctor)

Oncology Diagnosis	Protocol	Date of Diagnosis / /	Active Treatment ☐ No ☐ Yes	Date therapy ended / /
Relapse Diagnosis ☐ N/A	Relapse Protocol ☐ N/A	Date of Relapse / /	Relapse Therapy Ended / /	
Drug Allergies ☒ NKDA				Date of Tetanus Booster / /
Food Allergies				Is the camper allergic to peanuts? ☐ No ☐ Yes
Does the camper have a latex allergy? ☐ No ☐ Yes				
Weight KG	Date of Weight / /	Height		Date of Height / /
Flu Vaccination ☐ Yes ☐ No	Date of Flu Vaccination / /	Varicella Status ☐Had Varicella ☐ Recv'd Vaccination ☐Positive Titers		

IV. History (to be completed by doctor)

Central Line ☐ No ☐ Yes	Needle Size Gauge	☒ Hickman/Broviac ☒ Mediport/Port-a-cath ☒ PICC Other_____
Asthma ☐ No ☐ Yes	Seizures ☐ No ☐ Yes	
Prosthetic Device ☐ No ☐ Yes	Impairments ☐ No ☐ Yes	
Transplant ☐ No ☐ Yes	Surgeries ☐ No ☐ Yes	
Colostomy / Catheterization ☐ No ☐ Yes	Feeding Tube ☐ No ☐ Yes	
Social Concerns ☐ No ☐ Yes	Behavioral Issues ☐ No ☐ Yes	
Psychiatric Issues ☐ No ☐ Yes	Learning Disabilities ☐ No ☐ Yes	

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V. Physical (to be completed by doctor)

Vision ☐ NML ☐ ABNL	Neurological ☐ NML ☐ ABNL
Heent ☐ NML ☐ ABNL	Hearing ☐ NML ☐ ABNL
Abdomen ☐ NML ☐ ABNL	Teeth ☐ NML ☐ ABNL
Genitalia ☐ NML ☐ ABNL	Lung ☐ NML ☐ ABNL
Heart ☐ NML ☐ ABNL	Musculoskeletal ☐ NML ☐ ABNL
Comments (please address the above with any additional information that the CHT Medical Staff needs to have)	

VI. Medication (to be completed by doctor)

Note: You will be able to provide us with an updated list prior to camp for meds that might Δ, i.e. MTX, 6 MP. Please see contact information listed on the next page.

Prescription:	Dose	☐ Milligrams (MG) ☐ Milliliters (ML) ☐ Grams (G) ☐ Units (U) ☐ micrograms (MCG)	Frequency
	Route ☒ Intramuscular (IM) ☒ Oral (PO) ☒ Subcutaneous (SQ) ☒ Intravenous (IV)		
Prescription:	Dose	☐ Milligrams (MG) ☐ Milliliters (ML) ☐ Grams (G) ☐ Units (U) ☐ micrograms (MCG)	Frequency
	Route ☒ Intramuscular (IM) ☒ Oral (PO) ☒ Subcutaneous (SQ) ☒ Intravenous (IV)		
Prescription:	Dose	☐ Milligrams (MG) ☐ Milliliters (ML) ☐ Grams (G) ☐ Units (U) ☐ micrograms (MCG)	Frequency
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*Please attach an additional page if needed

VII. Limitations/Restrictions (to be completed by doctor).

Does the camper have any physical limitations? ☐No ☐ Yes	If Yes, Please explain
Does the camper have any physical restrictions? ☐No ☐ Yes	If Yes, Please explain

VIII. Physician Consent (to be completed by doctor)

I have examined the Camp Happy Times Applicant, who is physically able to engage in camp activities, except for any physical limitations and restrictions hereby noted. I affirm all information contained in this form is accurate and understand that the Licensed Camp Happy Times Physician will notify me in the event of a medical emergency. However, I understand that in a medical emergency, and in the Physician's best clinical judgment, the camper may require care at Wayne County Memorial Hospital, Honesdale, Pennsylvania. I also agree that if any of the information contained in the application changes prior to the 2017 session, I understand the importance and assume full responsibility of communicating the information promptly to CHT.

MD/DO/NP Name	Address			Suite
City	State	Zip	Phone	
Fax	Beeper	E-Mail		
→ MD/DO/NP Signature			Date	

Return Completed Medical Applications by June 15, 2017 to:

Camp Happy Times
2101 Millburn Avenue
Maplewood, NJ 07040

Fax to: 973-761-6792 Attn: Camp Happy Times
Scan and email to: sspriggs@thevaleriefund.org

Please Note:
If circumstances or medications change after June 15, 2017, a revised medication sheet can be submitted to the above address or via email to sspriggs@thevaleriefund.org. You can easily submit revisions via the Bus Departure Form which will be mailed out to you in early August. If you have any medical related questions please email Marianne Connelly at maconnelly@barnabashealth.org

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. If you have other camp related questions please email sspriggs@thevaleriefund.org or Millie Finkel at Milliesue@aol.com .