



# Kay's Kamp

## Physician/PNP Recommendations and Restrictions at Kamp

**THIS PAGE TO BE COMPLETED BY PHYSICIAN OR PNP**

I examined \_\_\_\_\_ (DOB) \_\_\_\_\_ on \_\_\_\_\_  
Kamper's Full Name Date of Most Recent Examination

Original Diagnosis \_\_\_\_\_ on \_\_\_\_\_ Facility Treating \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_ RR: \_\_\_\_\_

Last blood count: Date: \_\_\_\_\_ Hgb \_\_\_\_\_ Hct \_\_\_\_\_ WBC \_\_\_\_\_  
Platelets \_\_\_\_\_ ANC \_\_\_\_\_ Varicella Titer \_\_\_\_\_

Date of Bone Marrow Transplant/Stem Cell Transplant \_\_\_\_\_  
Date of last Chemotherapy \_\_\_\_\_ Radiation \_\_\_\_\_

Current physical and medical condition: X=within normal limits O=see remarks below

\_\_\_\_ scalp, skin    \_\_\_\_ heart    \_\_\_\_ vision    \_\_\_\_ ear, nose    \_\_\_\_ lungs  
\_\_\_\_ hearing    \_\_\_\_ throat    \_\_\_\_ abdomen    \_\_\_\_ neck    \_\_\_\_ eyes  
\_\_\_\_ genitalia    \_\_\_\_ teeth    \_\_\_\_ extremities    \_\_\_\_ lymph nodes    \_\_\_\_ nervous system

REMARKS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Chemotherapy: Please include a copy of current chemotherapy roadmap or regimen.

\_\_\_\_\_  
\_\_\_\_\_

I have read Kay's Kamp policies regarding CVL's and water sports/activities. **Yes No**  
(Available online at: [kayskamp.org/applications.htm](http://kayskamp.org/applications.htm))

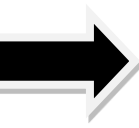
Description of any limitation, concerns or restrictions which would prevent kampers participation in Kamp activities:

\_\_\_\_\_  
\_\_\_\_\_

Any medically prescribed meal plan or dietary restrictions:

\_\_\_\_\_  
\_\_\_\_\_

I hereby verify that the information on the above form and preceding forms containing health matters and medications are correct. In my opinion, this child can participate in Kay's Kamp's summer program.



Signature of Physician/Practitioner \_\_\_\_\_  
Print Name \_\_\_\_\_ Date \_\_\_\_\_  
Phone \_\_\_\_\_

**(Fax completed form to: 302-834-0367)**