



# Camper Medical Form

Camp Quality Canada (an operating division of Camp Quality Incorporated) is a volunteer charitable organization that strives to improve the quality of life for children living with cancer through camps and year-round family support programs.

Charitable Reg. No. BN 13342 3962-RR0001

[www.campquality.com](http://www.campquality.com)

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**CAMP NAME:**

**RETURN FORM TO:**

**CAMP DATE:**

**RETURN DATE:**

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## MESSAGE TO PARENTS/GUARDIANS AND ONCOLOGIST/PHYSICIAN:

Children (siblings included) will not be permitted to attend Camp 2008 unless current medical information is provided to Camp Quality Canada. Current medical information is of paramount importance in ensuring the safety and well-being of the campers during their time at Camp Quality Canada.

**This form must be completed and signed by your child's oncology physician (or family physician if applicable) and returned to the National Office by the submission deadline date listed on the registration form.**

Please note that campers must bring all PRESCRIPTION medications to Camp 2008, in the original labelled container outlining the camper's name, drug, prescribed dosage and times to be taken each day. Campers must not bring non-prescription drugs (i.e. Aspirin) to Camp 2008.

If your child has been exposed to any viruses prior to going to Camp 2008 (e.g. measles, chicken pox, shingles), you must discuss this exposure with your child's physician to determine whether your child should attend Camp. The physician will be asked to note recent exposure to infections, blood count changes and other issues at section B of this form and to provide an update report just prior to Camp 2008, if appropriate.

**Failure to provide Camp Quality Canada with this completed document will disqualify the camper from attending camp 2008.**

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## REGARDING THE COMPLETION OF THE MEDICAL FORM:

In an effort to be considerate of both you and the Doctors' time, please note the following when completing **Camp Quality Canada, Camper Medical Form:**

- If your child is **in active treatment**, section B of this form must be completed by your child's oncologist. As you and your child will be seeing the oncologist regularly the form can be signed at that time.
- If your child is **not in active treatment** and therefore is not seeing the oncologist frequently (i.e. more than once a year), then section B of this form can be completed by your child's family doctor.

<p><b>If you have any questions or incur any charges related to the completion of this or other forms please call the Camper Registrar whose name is noted on the contact page on the website.</b></p>
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**To be completed by Oncologist/Physician:**

**A.**

Name of Child \_\_\_\_\_ Gender \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Surname) (First Name) (mm) (dd) (yr)

Address \_\_\_\_\_  
(No.) (Street Name) (Apt. No.) (City) (Prov.) (Postal Code)

Family Physician's Name: \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

Oncologist's Name: \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

**B.**

**To be completed by Oncologist/Physician:**

Primary Diagnosis: \_\_\_\_\_ Date of onset: \_\_\_\_\_

Secondary Diagnosis if Applicable: \_\_\_\_\_

Surgical Interventions and Dates:  
\_\_\_\_\_

Allergies: (Drugs, Insect Bites, Foods, etc.)  
\_\_\_\_\_

Off All Treatment  Yes  No Since: \_\_\_\_\_  
(mm) (dd) (yr)

**CURRENT TREATMENT:**

1. (a) Chemotherapy

Drug	Dosage	Times taken
_____	_____	_____
_____	_____	_____

Chemotherapy to be given at camp?  Yes  No

Date of most recent chemotherapy session: \_\_\_\_\_  
(mm) (dd) (yr)

Side Effects to watch for:  
\_\_\_\_\_

(b) Other Medications

Drug	Dosage	Times taken
_____	_____	_____
_____	_____	_____

**2. Other Treatments:** *(Dressings, catheters, prosthesis: Procedures/solutions preferred)*

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Central Line? \_\_\_\_\_ Hickman? \_\_\_\_\_ Portacath? \_\_\_\_\_

Radiation? \_\_\_\_\_ Routine outpatient treatment? \_\_\_\_\_

Flush routine during week of camp: \_\_\_\_\_

Will the child bring his/her own treatment materials?  Yes  No

**3. Special Needs/Precautions/Limitations:** *(List any restrictions in physical activities, diet, swimming, recent exposure to infections, blood count changes and other issues) Attach additional comments if necessary.*

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**ADDITIONAL COMMENTS:**

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**DOCTOR'S ACKNOWLEDGMENT:**

Subject to the above precautions and limitations, there are no contraindications to his/her attendance at Camp Quality Canada.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please Print: Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**OTHER COMMENTS:** *(attending physician/camp health care professional)*

Please use back of sheet or attach additional page if necessary.

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