



Good Heart, Good Times, Good Friends!

Cardiac Staff Medical Forms 2010

Please return the following completed medical forms by June 4th, 2010 to:

Camp Bon Coeur
405 W. Main St.
Lafayette, LA 70501
Phone: (337) 233-8437
Fax: (337) 233-4160

Incomplete forms will not be accepted by the camp office!

DIRECTIONS FOR MEDICAL FORMS

The following medical forms must be completed for all campers and staff by the individuals indicated. Please read the following directions carefully! **Please print or type information!** All forms received by Camp Bon Coeur will be checked for completeness. If any information is missing, the form(s) will be returned to you. This may be a factor in the applicant's admittance to camp.

PARENT/LEGAL GUARDIAN – complete pages **1, 2, and 3: HEALTH AND PERSONAL HISTORY DATA**. This form must **be completed by the legal parent/guardian** of applicants or staff members who are under the age of 18. Staff members who are 18 years of age or older must complete this form.

PRIMARY CARE PROVIDER (MD or NP) – complete pages **4 and 5: MEDICAL EXAMINATION FORM**. This form is to be **completed by a licensed physician or nurse practitioner within six (6) months** prior to encampment. It should be filled out at the time of physical examination. **We must have the original signature on file. You may fax the forms first to make the deadlines, but please mail us the originals after.**

PEDIATRIC CARDIOLOGIST – complete pages **6 and 7: CARDIOLOGY INFORMATION FORM**. Also, please complete page **8: ACTIVITY PARTICIPATION FORM**. These forms should be **completed by the applicant's pediatric cardiologist**. This information is extremely important in determining the camper's suitability for participation in camp activities. Please include a copy of the most recent clinic letter, and if possible, a diagram of the child's heart for teaching purposes. **We must have the original signature on file. You may fax the forms first to make the deadlines, but please mail us the originals after.**

Page 1: CAMP BON COEUR - HEALTH AND PERSONAL HISTORY DATA:

To be completed by the legal **parent/guardian** of minors or by staff members over 18 years of age.

Applicant's Last Name	First	Middle	Nickname	Date of Birth	Age	Grade
						()
Address	Apt.#	City	State	Zip	Home Phone	
				()	()	
Mother's Name	Home Phone			Cell Number		
				()		
Mother's Work Place	Hours/Days of Work			Work Phone		
				()		
Father's Name	Home Phone			Cell Number		
				()		
Father's Work Place	Hours/Days of Work			Work Phone		
				()		
Name of Person to Contact in Case of EMERGENCY / Relation				EMERGENCY PHONE		

PLEASE INDICATE THE LEGAL PARENT(S) / GUARDIAN WITH AN * IN FRONT OF THE NAME ABOVE

Please provide the following:

Name:	Address:	Phone
_____	_____	() _____
Primary Care Physician	_____	
or	_____	Fax
Health Care Provider	_____	() _____

Name:	Address:	Phone
_____	_____	() _____
Pediatric Cardiologist	_____	
	_____	Fax
	_____	() _____

	Address:	Phone
_____	_____	() _____
Transplant coordinator	_____	
or	_____	Fax
Other Specialist _____	_____	() _____

Has the applicant had a heart transplant? Yes No

If yes, date of transplant _____

What type(s) of medical insurance coverage does your child have? Please indicate:

INSURANCE PROVIDER NAME: _____

PRIMARY POLICY HOLDER'S NAME: _____

POLICY/GROUP NO.: _____

Please attach a copy (front and back) of the applicant's insurance or Medicaid card to this form.

Page 2: CAMP BON COEUR - HEALTH AND PERSONAL HISTORY DATA

Parent or Legal Guardian complete the following:

Does the applicant *now have* or has the applicant *ever had*:

		(Circle)
1.	Allergic reaction to:	Yes No
	a. Medications <i>(if yes, please list below which medications)</i>	Yes No
	b. Foods <i>(if yes, please list below which foods)</i>	Yes No
	c. Insect stings	Yes No
	d. Pollens / hay fever	Yes No
	e. Animal dander	Yes No
2.	Chronic/Recurrent illnesses <i>(if yes, please describe below)</i>	Yes No
3.	Bleeding disorder or easy bruising If yes, is he/she on Coumadin? Yes No	Yes No
4.	Asthma or shortness of breath	Yes No
5.	Seizures	Yes No
6.	Fainting episodes or dizzy spells	Yes No
7.	Stroke / paralysis	Yes No
8.	Hypertension (high blood pressure)	Yes No
9.	Diabetes	Yes No
10.	Migraine headaches	Yes No
11.	Strep throat	Yes No
12.	Ear / sinus infections	Yes No
13.	Pneumonia	Yes No
14.	Skin problems <i>(itching, rashes, hives, acne)</i>	Yes No
15.	Hepatitis	Yes No
16.	Immunosuppression or immunocompromise <i>(can get infections easily)</i>	Yes No
17.	Bowel or bladder problems	Yes No
18.	Orthopedic problems	Yes No
19.	Learning difficulties	Yes No
20.	Attention deficit disorder / hyperactivity	Yes No
21.	Emotional or behavioral problems	Yes No
22.	Eating disorders <i>(anorexia nervosa/bulimia)</i>	Yes No
23.	A problem with sleepwalking	Yes No
24.	A problem with bedwetting	Yes No
25.	<i>(For females only)</i> Irregular menstrual periods or severe cramps Age at onset of menses: _____	Yes No

*Please explain in detail any "yes" answers, noting the number of the questions and dates (or age) of occurrence.

I have, to the best of my ability, accurately provided the information requested on pages 1-3.

Signature of Legal Parent/Guardian

Date

Driver's License No. / State

Page 3: CAMP BON COEUR - HEALTH AND PERSONAL HISTORY DATA

Parent or Legal Guardian complete the following:

Has the applicant ever had chicken pox? Yes No

If yes, at what age? _____

If no, has the applicant ever received a varicella (chicken pox) vaccine? Yes No

Are the applicant's immunizations up-to-date? Yes No

Immunization	Date of last vaccine	Immunization	Date of last vaccine
Td / Tetanus	_____	Hepatitis B	_____
DTaP	_____	Polio	_____
MMR	_____	Varicella	_____
Hib (H. influenza B)	_____	Pneumococcal	_____

Note: Td/Tetanus or DTaP must be within the past 10 years (Please send copy of immunization record)

(For Staff only): Date of most recent Tuberculin skin test _____ Result _____

(Note: TB skin test must be within the past 12 months)

Does the applicant have:		
1.	Any special dietary needs or restrictions (<i>if yes, please attach and explain any special diet that is being followed</i>)	Yes No
2.	Glasses, contact lenses, or protective eye wear	Yes No
3.	Dental devices (<i>bridges, retainers, braces</i>)	Yes No
4.	Braces, splints, or other orthopedic appliances (<i>if yes, please explain</i>)	Yes No
5.	Other special needs, ie. Oxygen (<i>if yes what concentration/flow and how often, please explain. CBC CAN ONLY PROVIDE OXYGEN IN CASE OF AN EMERGENCY</i>)	Yes No
6.	Any activity restrictions (<i>if yes, please explain</i>)	Yes No
	Does the applicant participate in physical education classes at school? If yes, _____ standard PE classes or _____ adaptive PE classes (check one)	Yes No

Please use this additional space if needed to further explain any of the above:

Please list all of the applicants Medications:

Name	Dose	How often	Preferred times	Reason for taking
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Page 4: CAMP BON COEUR – MEDICAL EXAMINATION FORM

This Medical Examination Form is to be **completed by a licensed physician or nurse practitioner** at the time of the examination, which must be within six (6) months prior to encampment.

Please print or type only.

Please be sure to include the patient's immunization information.

Name: _____ Gender: M F Age: _____
 Date of Birth: _____ Weight: _____ Height: _____

Cardiac Diagnoses: _____

Current Medical Problems: _____

PAST HISTORY:

Hospitalizations:

Date: _____	Institution: _____	Reason: _____	None: _____
Date: _____	Institution: _____	Reason: _____	
Date: _____	Institution: _____	Reason: _____	
Date: _____	Institution: _____	Reason: _____	

Surgical / Interventional Procedures:

Date: _____	Procedure: _____	Institution: _____	None _____
Date: _____	Procedure: _____	Institution: _____	
Date: _____	Procedure: _____	Institution: _____	
Date: _____	Procedure: _____	Institution: _____	

Medications: None

Name	Dose	Route	Frequency	Preferred times	Indication

If patient is on Coumadin: Most recent INR: _____ Date: _____ How often Checked: _____

ALLERGIES: <input type="checkbox"/> None <input type="checkbox"/> Yes	Type of Reaction
If yes, name of medication(s): 1.	
2.	
3.	
Other allergies:	

IMMUNIZATION RECORD: Please complete or send legible copy of immunization record

Immunization	Date of last vaccine	Immunization	Date of last vaccine
Td / Tetanus	_____	Hepatitis B	_____
DTaP	_____	Polio	_____
MMR	_____	Varicella	_____
Hib (H. influenza B)	_____	Pneumococcal	_____

Note: Td/Tetanus or DTaP must be within the past 10 years
 (For Staff only): Date of most recent Tuberculin skin test _____ Result _____
 (Note: TB skin test must be within the past 12 months)

Page 5: CAMP BON COEUR – MEDICAL EXAMINATION FORM

REVIEW OF SYSTEMS:

Hearing / Vision Problems	Yes	No
Stroke / Weakness	Yes	No
Seizures	Yes	No
Syncope	Yes	No
Migraine Headaches	Yes	No
ADD / ADHD	Yes	No
Cyanosis	Yes	No
Asthma / RAD	Yes	No
Respiratory Infections	Yes	No
Sinus Problems / Otitis	Yes	No
Nose Bleeds	Yes	No
Coagulopathy	Yes	No
Anemia	Yes	No
Asplenia	Yes	No
Chest Pain/Angina	Yes	No

Arrhythmias	Yes	No
Palpitations	Yes	No
Hypertension	Yes	No
Edema	Yes	No
Kidney / Bladder Problems	Yes	No
Diabetes / Endocrine Problems	Yes	No
Skin Problems / Rashes	Yes	No
Musculoskeletal Disease / Injury	Yes	No
Upper G.I. Problems	Yes	No
Diarrhea / Constipation	Yes	No
Hepatitis	Yes	No
Mononucleosis	Yes	No
Strep infections	Yes	No
Emotional / Behavioral Problems	Yes	No
Other:	Yes	No

Please give details for any "Yes" answers:

PHYSICAL EXAMINATION:

Date: _____

Vital Signs: Pulse _____ Resp. _____ Blood Press _____ / _____ Pulse Ox. _____ %

General _____

Head _____

Eyes _____

Ears _____

Are P.E. tubes present? ___Yes* ___No
If yes, is it OK for him/her to go underwater? ___Yes ___No

Nose _____

Throat _____

Chest _____

CV _____

Abd _____

M/S _____

Neuro. _____

Developmental
(If delayed, be specific) _____

Lab data: Date: _____ Hct _____ Hgb _____ Other: _____

I have, to the best of my ability, provided the information on this medical examination form accurately.

MD/NP's Signature _____ Date _____ Please print or stamp office address here:

Phone: _____

Are there any over-the-counter medications that the patient SHOULD NOT take? ___No ___Yes

If yes, please list medication and reason: _____

Recommended SBE prophylaxis:

___None ___Standard Amoxicillin regimen ___Erythromycin ___Other (describe)

If patient is on Coumadin: Most recent INR: ___ Date: ___ How often checked: ___

Does the applicant have any arrhythmias? ___No ___Yes Describe: _____

Is the applicant cyanotic? ___ No ___ Yes - Last pulse ox reading: _____%

Has the applicant had a cardiac transplant? ___ No ___ Yes

If yes, please include the name, address and phone number of the Transplant Coordinator:

Name: _____ Phone: _____

Address: _____

Note: In our Heart Program, a pediatric cardiologist or cardiology nurse practitioner teaches the campers about their hearts. Please include any other information that you think may be important or helpful for the camp physicians and nurses in the education or care of this applicant:

Please attach a copy of the applicant's last clinic letter with this form. Thank you.

I have, to the best of my ability, provided the information on this medical examination form accurately.

Signature _____

Please submit **COMPLETED** forms to

Camp Bon Coeur
405 W. Main St. LAFAYETTE, LA 70501
Phone: (337) 233-8437 • Fax: (337) 233-4160

We must have the original signature on file. You may fax the forms first to make the deadlines, but please mail us the originals after.

Page 8: CAMP BON COEUR – ACTIVITY PARTICIPATION FORM

This Activity Participation Form is to be **completed** by the applicant's **pediatric cardiologist or cardiology nurse**. Camp Bon Coeur encourages participation in all activities. However, if a camper becomes fatigued, he/she will be allowed to rest as needed. Keep in mind that Camp Bon Coeur, located in Eunice, Louisiana, is thirty-seven (37) feet above sea level. **The pediatric cardiologist must sign this form. Please print or type only.**

APPLICANT'S NAME: _____ DOB: _____

Please circle the appropriate letter below which best describes the activity level for this camper.

- A. **Full active participation** – Camper is able to engage in non-competitive, non-contact games requiring moderate exercise, which may involve running short distances.
- B. **Partial active participation** – Camper is able to engage in limited activities requiring minimal physical effort and may require occasional rest periods.
- C. **Limited active participation** – Camper is able to engage in sedentary activities only requiring no physical effort and must rest frequently. Camper can, however, benefit from attendance at Camp Bon Coeur.
- D. **No active participation** – Camper is physically, emotionally, or mentally unstable and should not attend camp at this time.

CAMP ACTIVITIES IN WHICH THIS APPLICANT MAY PARTICIPATE

Please indicate this applicant's physical ability to participate in each activity. You may be contacted if the Camp Bon Coeur staff have any questions regarding your responses below.

___Yes ___No Applicant participates in a school physical education program.
If yes, ___Full active participation ___Partial active participation
If no, please provide further information below.

Is the applicant able to participate in:

- ___Yes ___No Instructional and recreational swimming?
- ___Yes ___No Jumping (feet first) into the swimming pool?
- ___Yes ___No Bowling?
- ___Yes ___No Horseback riding (no cantering/galloping)?
- ___Yes ___No Archery?
- ___Yes ___No Gym recreational activities- ball and floor games - in air conditioning?
(floor hockey, whiffle ball, soccer drills, volleyball, basketball)
- ___Yes ___No Team relay activities (light running)?
- ___Yes ___No Aerobic activities (low intensity/low impact)?
- ___Yes ___No Walking up and down a flight of stairs several times a day?
- ___Yes ___No Walking on the nature trail (approx. ¼ mile)?
- ___Yes ___No Is the applicant able to walk 150 yards **without extreme fatigue**?
- ___Yes ___No Activities outside in extreme heat and humidity?

If the answer to any of the above is "no", please explain: _____

I have, to the best of my ability, provided the information on this medical examination form accurately. _____ Please print or stamp office address here:

Pediatric Cardiologists' signature _____ Date _____ Phone: _____ **Please mail/fax this form to: CAMP BON COEUR INC, 405 W. Main St., LAFAYETTE LA 70501 Phone: (337) 233-8437 • Fax: (337) 233-4160**