❑ Camp Crescent Moon (ages 7-14)
❑ Camp Gibbous (ages 15-18)
Health History & Physical 20____

Sickle Cell Disease Foundation
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For office use only
❑ Camper ❑ Volunteer
❑ Complete ❑ Incomplete
❑ Approved ❑ Pending
❑ Rejected ❑ ____________
Reviewed by: ____________
Date: _____/______/______

Release of Information

Information in this document is protected by HIPAA privacy laws and should be handled accordingly.
A new form must be completed annually for attendance.

Note to Parent/Guardian: The Sickle Cell Disease Foundation (SCDF) wants the camp experience to be a safe and healthy one. However in the event of an accident or illness, it is important that we have the following information.

1. Proof of physical examination, verified by Physician's signature
2. Copy of Medical Insurance Information, and
3. Copy of Immunization record

Please PRINT all information

Child's Name: ____ ❑ **Female** ❑ **Male**
Last First Middle

Date of Birth: _______/_______/_______ **Age:** __________ **Height**: ___________ **Weight**: ______________

Blood Pressure : ____________ **Temperature :** ____________ **Pulse :** ___________ **Respiration :** ___________

Laboratory : HB Electrophoresis Type : ❑ **SS** ❑ **SC** ❑ **S/Thal** ❑ **Other**:______________________________

Latest Hemoglobin : ____________gm/dl **Hematocrit :** _____________% **Date :** ______/______/______

Baseline O2 Saturation on Room Air: ______________% **Date :** _______/_______/_______

Other Pertinent Lab Data:____

General Appearance: (Describe skin, sclera, etc.) ____________________________________
____
____

Cardiomegaly: ❑ Yes ❑ No Murmur: ❑ Yes ❑ No Describe: ______________________________

Chest X-Ray: Date: ______________ Normal: ❑ Yes ❑ No Describe: ______________________

EKG: Date: _______________ Normal: ❑ Yes ❑ No Comment: _____________________________
____

Spleen: Enlarged ❑ Yes ❑ No CM from LCM: ________________________________

Liver: Enlarged ❑ Yes ❑ No CM from RCM: ________________________________

Hernia: ❑ Yes ❑ No Umbilical: ____________________ Inguinal: ____________________

Has child had the following:

Condition		Comments	Condition		Comments
Asthma or Wheezing	❑ Yes ❑ No		Hay fever	❑ Yes ❑ No	
Avascular Necrosis	❑ Yes ❑ No		Kidney Disease	❑ Yes ❑ No	
Convulsions	❑ Yes ❑ No		Leg Ulcers	❑ Yes ❑ No	
CHF	❑ Yes ❑ No		Meningitis	❑ Yes ❑ No	
CVA/Stroke	❑ Yes ❑ No		Osteomyelitis	❑ Yes ❑ No	
Chronic Transfusion Program	❑ Yes ❑ No		Pneumonia	❑ Yes ❑ No	
Eczema or Skin Rashes	❑ Yes ❑ No		Recent Infection	❑ Yes ❑ No	
Gallstones	❑ Yes ❑ No	Symptoms ❑ Yes ❑ No	Other:	❑ Yes ❑ No	

Child's Name/Patient: ____ **DOB**: _____/_____/______

ALLERGIES: Please list any **allergies** including reaction and treatment: (drugs, food, environment, poison ivy, insect stings, other): ❑ None ❑ Unknown ____

____

Usual pattern of crisis: ____

Does fever accompany crisis? ❑ Yes ❑ No

Recent crisis: ❑ Yes ❑ No Type: ____ Date: ______________________

Number of days of usual crisis: __________________ Number of hospital stays last year: _________________________

Reason for last hospitalization: ____ Date: ________________

Operations & Dates: ____

Does child take medications (prescribed, herbal, alternative, other, etc.)? ❑ Yes ***(if yes, list below)*** ❑ No

Please list ALL medications *(attach separate sheet if necessary)*

Medication	Dose	Frequency	Reason	Currently Taking
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Menstrual Period: ❑ Yes ❑ No ❑ N/A Cramps: ❑ Yes No ____

Usual cycle of menstrual period (i.e., every 28 days): ____

Special considerations to be watched for such as allergy (i.e., reaction to food, penicillin or other drugs), bed wetting, constipation, fainting, sleep walking, etc.:____

____

____

Emotional response to illness: ❑ Mild ❑ Moderate ❑ Severe ❑ None ❑ Unknown ___________________________

History of emotional or behavioral disturbance: ❑ Yes ❑ No If yes, please describe: ______________________________

____

Diagnosed with **ADD**: ❑ Yes ❑ No **ADHD**: ❑ Yes ❑ No ____

How long has child been your patient? ________ years ________ months

Hospital where child is usually admitted: ____________________________________ Phone: ( ) ________________

Form completed by: ____ Date of completion: ______________________

Physician's Signature: _________________________________ Date: ______________ Print Name: __________________

Address: ____ City/St/Zip: ____________________________________

Phone: ( ) ____________________________________ Fax: ( ) _________________________________

PARENTS/GUARDIANS: Please complete this area BEFORE SENDING TO THE SCDF

Parent's Name (print): ____ Signature: ____________________________

Address: ____ City/St/Zip: ____________________________________

Cell Phone: ( ) ________________________________ Home Phone: ( ) _________________________________

Work ( ) ______________________________________ email: ____