Camp Crescent Moon

MAIL FORMS TO: Sickle Cell Disease Foundation of California
3602 Inland Empire Blvd., Suite B140, Ontario, CA 91764
Phone (909) 743-5226 • Fax (909) 743-5227 • email: deborahg@scdfc.org

HEALTH HISTORY/PHYSICAL TO BE FILLED OUT BY A PHYSICIAN ONLY

To Practitioners filling out the sickle cell camp pre-participation physicals,

Attached is a health history and physical application for Camp Crescent Moon, a summer camp for children with sickle cell disease ***(sickle cell trait does not qualify)***.

Camp Crescent Moon is scheduled for the week of July 13-20, 2019, however the application is **due to the SCDFC no later than Saturday, June 1st.**

Please complete the health history form in its entirety, do not leave any areas incomplete. It will delay the child's application and acceptance in the program.

We ask that you provide the most recent lab data **(within six (6) months)** to ensure our ability to provide the best medical care possible patient while he or she attends camp.

In previous years, we received a number of physical exam forms that were missing critical information, such as type of sickle cell disease, hemoglobin/hematocrit and/or height/weight.
While caring for your patients at the week-long camp, such information is necessary for calculating drug doses for example or for establishing differential diagnosis. As you can imagine, this kind of information might be crucial for a particular acute situation in the camp setting, which is typically in a rural location.

Thus, we implore you to help us take better care of your patients by providing us with the information requested. If your nurse or other personnel is filling out the form, please review the form carefully before signing and sending it in.

Please keep in mind that we will contact you by mail prior to camp to provide us with any medical updates or changes in the status of the child.

If we can be of any assistance to you, please do not hesitate to call the SCDFC at (909) 743-5226.

Sincerely,

Cage S. Johnson, MD
Medical Director, Camp Crescent Moon

Camp Crescent Moon

Health History and Physical 20__

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Release of Information

Information in this document is protected by HIPAA privacy laws and should be handled accordingly. This form is only good for travel to and from, and attendance at Camp Crescent Moon; it may not be used for any other purpose. A new form must be completed annually for attendance.

Note to Parent/Guardian: The Sickle Cell Disease Foundation of California (SCDFC) 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

For office use only
❑ Camper ❑ Volunteer
❑ Complete ❑ Incomplete
❑ Approved ❑ Pending
❑ Rejected ❑ _____
Reviewed by: _____
Date: _____/_____/_____

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:

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 _____

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 SCDFC

Parent's Name (print): _____ Signature: _____

Address: _____ City/St/Zip: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell: ( ) _____ email: _____