Camp Smile-A-Mile, P. O . Box 550155, Birmingham, AL 35255
205-323-8427 phone #, 205-323-6220 fax #,
toll free 888-500-7920
www.campsam.org

PATIENT MEDICAL HISTORY FORM

Required by all patients by May 18 for Youth Camp and for Jr/Sr Weekend and Teen Camp then by June 20)– extended for new campers or if you call the camp office for an extension. Camp Smile-A-Mile will not be able to get this form completed for you. You must obtain a doctor signature on the last page. Please provide complete info. so we can be aware your child's needs.

Name _____ **Birth Date**_____ **Age at Camp** _____
first middle last

Diagnosis _____ **Date of Diagnosis** _____ **Phase of Treatment** ☐ **on** ☐ **off therapy**

If the diagnosis is a type of tumor, please list location of tumor_____

Date of Last Chemotherapy or Treatment?_____ **How long have you been off therapy?**_____

Bone Marrow Transplant? Yes ☐ **No** ☐ **If yes, month & year?**_____

Home Phone _____ **Gender** *Male Female*

Parent/Guardian _____ _____
name relationship

Parent/Guardian Email Address_____

Patient Address_____

City_____ **State**_____ **Zip** _____

Is the above address the same for the parent/guardian? ___Yes ___No If No, please list address, city, state and zip below.

_____

Mom Work Phone _____ **Mom Cell Phone** _____

Dad Work Phone _____ **Dad Cell Phone** _____

Name of Oncologist & Nurse Practitioner _____
Phone # & Hospital Name _____

Name of Pediatrician _____ Phone _____
Address _____

Other Physician(s) _____ Phone _____
(Helping treat other medical conditions)
Address_____
Reason(s) for treatment_____

Allergies - List all known.
Medication Allergies- i.e.-penicillin, codeine, Phenergan, Sulfa Describe reaction and management of the reaction

_____ _____

_____ _____

Food Allergies- i.e.-peanuts, shellfish, lactose intolerant

_____ _____

_____ _____

Other Allergies – Include insect stings, hay fever, asthma, etc.

_____ _____

_____ _____

Dietary Restrictions (circle one): none yes, describe below
Vegetarian: ☐ **yes** ☐ **no** ____ Other (describe) _____

Camp Smile-A-Mile
Alabama's Program for Children with Cancer

Patient's Name_____

SPECIAL NEEDS

Please list any physical restrictions or activity limitations (i.e.- no swimming, no prolonged sun exposure, no competitive sports, sight or hearing loss, limb amputation, has difficulty walking distances, requires assistance to dress or eat).

_____

_____

_____

Is there anything we should know about your child that will make his/her adjustment smoother?

_____

_____

Is your child able to function at his or her age level? Please describe.

_____

_____

Describe any unusual bedtime or sleep habits:

_____

_____

Does your child have any serious fears? Please describe:

_____

_____

Please indicate any further information about your child's medical or emotional needs that you feel we should know.

_____

_____

EMERGENCY CONTACT INFO (Parents will be contacted first. Please list others)

EMERGENCY CONTACT PERSON # 1 _____

PHONE_____**RELATIONSHIP**_____

EMERGENCY CONTACT PERSON # 2_____

PHONE_____**RELATIONSHIP**_____

INSURANCE COMPANY INFO

Is the camper covered by family medical/hospital insurance?_____

If yes, indicate Primary Care Name of Insurance Holder (ie-parent or patient name)

_____

If the insurance is not in the patients name, list the insured's relationship to the patient_____

Date of Birth of Primary Care Name _____ **SS #**_____

Carrier or Plan Name_____ **Group #**_____

Carrier address_____

Social Security number of policy or insurance ID #_____

PLEASE ATTACH A COPY OF THE FRONT & BACK OF THE INSURANCE CARD ABOVE TO THIS FORM!!!!

Camp Smile-A-Mile
Alabama's Program for Children with Cancer

Patient's Name_____

GENERAL QUESTIONS (Explain "yes" answers in the space provided to the side of each question.)

Has your child / Does your child:

1. Had any recent injury or infectious disease? Y N _____
2. Have a chronic or recurring illness/condition other than cancer? Y N _____
3. Been hospitalized in the last 18 months? Y N _____
4. Had surgery in the last 18 months? Y N _____
5. Have frequent headaches? Y N _____
6. Ever had a head injury? Y N _____
7. Ever been knocked unconscious? Y N _____
8. Wear glasses, contacts or protective eye wear? Y N _____
9. Ever passed out during or after exercise? Y N _____
10. Ever been dizzy during or after exercise? Y N _____
11. Ever had seizures? Y N _____
12. Ever had chest pain during or after exercise? Y N _____
13. Ever had frequent ear infections? Y N _____
14. Have an orthodontic appliance? Y N _____
15. Have a history of bed wetting? Y N _____
16. Ever had high blood pressure? Y N _____
17. Ever been diagnosed with a heart murmur? Y N _____
18. Ever had back problems? Y N _____
19. Ever had problems with joints (knees, ankles)? Y N _____
20. Have any skin problems (itching, rash, acne)? Y N _____
21. Have diabetes? Y N _____
22. Have asthma? Y N _____
23. Had mononucleosis in the past 12 months? Y N _____
24. Had problems with diarrhea/constipation? Y N _____
25. Have problems sleepwalking? Y N _____
26. If female, begun menstrual cycle? Y N _____
27. Ever had an eating disorder? Y N _____
28. Have ADD/ADHD? Y N _____
29. Ever been treated for depression? Y N _____
30. Ever been treated for blindness or deafness? Y N _____
31. Ever had problems with temper tantrums? Y N _____
32. Have Down Syndrome? Y N _____
33. Use crutches, wheelchair, walker, prosthesis, electric scooter? (You are required to send this equipment to camp.) Y N _____

New patients, please attach your child's blue immunization form to this medical form or a copy of it. We realize that not all children will have had up-to-date immunizations due to being on chemotherapy. However, the dates marked on the 'blue form' will help us inform parents if children are exposed to the chicken pox or shingles at camp. This form will remain in the camp office and please send a renewed form each year if or as immunizations are updated.

PLEASE NOTE: If your child has been exposed to any communicable disease, particularly chicken pox, measles or mumps 1-3 weeks prior to camp, please contact us as soon as possible.

Please attach a copy of your child's insurance/Medicaid card and a copy of their blue immunization form.

Camp Smile-A-Mile
Alabama's Program for Children with Cancer

Patient's Name_____

Medications

The health hut will store and administer any medications needed during the camp. **Please send all medications to camp with your child in their original container with written instructions**. It is expected that each family will supply in advance any routine medications needed.

Please have your doctor write an order describing the dose and method of administration (including chemotherapy, TPN, antibiotics or other infusions). It is necessary for you to arrange the transport of these medications to camp.

PARENT SIGNATURE REQUIRED BELOW

*****PARENT/GUARDIAN AUTHORIZATIONS: This health history below is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted by me or my child's physician.**

Parent Signature_____Printed_____Date_____

Parent Comments_____

If your child is on therapy, please send the most recent blood counts to camp with your child.

_____ My child takes no medication on a routine basis.

_____ My child has a port. _____ My child has a central line.

*If your child has a central line, please send the necessary supplies for central line care and flushing. Send enough supplies for at least two daily dressing changes.

____ My child takes the following medications on a routine basis:

*Please include over-the-counter drugs too.

Drug Name	Dosage	Frequency	Reason

Use additional sheets as necessary to describe the care needed for your child.

Camp Smile-A-Mile
Alabama's Program for Children with Cancer

THIS PAGE TO BE COMPLETED BY PHYSICIAN
Physician Recommendations and Restrictions at Camp

I examined _____ on _____.
patient*'s full name* *date of most recent examination*

Weight _____ Height _____ BP _____

Last blood count : Date _____ Hgb _____ Hct _____ WBC _____Platelets_____

If the patient is on therapy, please list current protocol number, phase and week as applicable.

If patient is off therapy, please list protocol number used for treatment and date therapy was completed.

_____

_____

Current physical and medical condition:

_____

_____

_____

Any medically-prescribed meal plan or dietary restrictions: _____

_____

_____

Description of any limitation, concern or restriction on camp activities:

_____

_____

_____

I hereby verify that the information on the above form and preceding forms concerning health matters and medications is correct. In my opinion, this child is able to participate in Camp Smile-A-Mile's Year Round Programs.

Signature of Physician _____

Print Name _____ Date _____

Phone: _____