2024 CAMPER MEDICAL FORM

Flying Horse Farms strives to provide children with the safest and most magical experience while visiting camp. To do so, we need as much information as possible from the caregiver and medical provider regarding the camper's current medical status.

Return all forms and records to the FHF Admissions Team by one of these three methods:

Email: campers@flyinghorsefarms.org **Fax:** 419.751.7070

Mail: Flying Horse Farms, ATTN: Admissions Team, 5260 State Route 95, Mt. Gilead, OH 43338

If you have any questions, please contact Flying Horse Farms at 419.751.7077.

The following should be completed by the Medical Specialist (please type or print legibly)

PATIENT INFORMATION

Camper Name: _____

Date of Birth: _____

Caregiver Name: _____

Phone Number: _____

Date of Last Exam: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Medication Allergies: _____

Forbidden Over the Counter Medications: _____

Previous Surgeries or Anticipated Procedures: _____

PLEASE ATTACH THE FOLLOWING RECORDS

☐ Copy of most recent clinic visit note and after visit summary.

☐ Copy of most recent laboratory and/or imaging reports, if pertinent.

PHYSICAL EXAM (SKIP THIS SECTION IF LAST CLINIC NOTE PROVIDED)

☐ *See attached medical records*

Height: Weight:

Blood Pressure: Heart Rate:

O2 SAT:

	Normal	Abnormal	Comments:
HEENT			
Neck			
Lungs			
Heart			
Abdomen			
Muscular/Skeletal			
Lymph			
Neuro			
Skin			
Psych			
Other			

PSYCHOSOCIAL INFORMATION

☐ *See attached medical records*

Has the camper ever been diagnosed with any of the following? Check all that apply:

	ADD/ADHD
	Anxiety
	Autism Spectrum Disorder
	Bipolar Disorder
	Depression
	Developmental Delays
	Mood Disorder
	Obsessive Compulsive Disorder

	Oppositional Defiance Disorder
	PICA
	Post Traumatic Stress Disorder
	Reactive Attachment Disorder
	Other (please specify):

MEDICAL ACTION PLAN – *Please fully complete this section.*

What are the early warning signs/symptoms that the camper may be getting ill?

What could trigger this?

What non-medical interventions does the camper use at home? (i.e. ice, heat, rest)

What medical interventions does this camper use at home? (i.e. medications)

What are the signs and symptoms that the camper requires further evaluation?

DURING CAMP, WOULD YOU SUGGEST:

Campers will have the opportunity to participate in the following activities: boating, fishing, pool/swimming, hiking, archery, exposure to animals (dogs), a high and low ropes course, and campfires. All activities are adaptable to campers and are overseen by our medical team. Please check all boxes that apply:

- ☐ No activity restrictions necessary.
- ☐ May participate in all activities but allow for breaks as needed.
- ☐ No strenuous activities should be permitted. Frequent breaks will be necessary.
- ☐ No contact sports due to medical risk or equipment.
- ☐ The camper should not be around animals due to medical conditions.
- ☐ The camper will need transport around camp (wheelchair or golf cart).

Additional considerations that may assist us in caring for this camper:

SIGNATURES

I understand that the above listed individual is seeking to participate in a special overnight camp for children with serious illnesses, which provides a medical team consisting of specialty physicians, nurses, and mental health professionals who will be on site and on call 24 hours a day to provide medical care during camp.

Flying Horse Farms is growing, and we need your help! To make the best decisions for your patients, other campers, and our staff, please provide the following critical feedback. Please check all boxes that apply.

- ☐ My patient would MEDICALLY benefit from camp.
- ☐ My patient would EMOTIONALLY benefit from camp.
- ☐ My patient is struggling with their medical diagnosis: ☐ New Diagnosis ☐ Chronic Diagnosis
- ☐ My patient could attend a non-medical camp.
- ☐ My patient could NOT attend a non-medical camp.

Need for camp: ☐ HIGH ☐ MEDIUM ☐ LOW

Please comment:

Who expressed interest in coming to camp? ☐ CAREGIVER ☐ CHILD

Any additional comments:

Form filled out by: _____

Provider's signature: _____

Date: _____

Hospital/Affiliation: _____

Email: _____

Office Phone: _____

Office Fax: _____