2025 CRANIOFACIAL 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: _____

Craniofacial Disorder: *(please include date of DX)* _____

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.

☐ Specific treatment guidelines for high-risk activities.

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	☐	☐	

AIRWAY

What is the camper's baseline oxygen saturation?

Does the camper require supplemental oxygen or a breathing machine? ☐ Yes ☐ No

When is supplemental oxygen required? ☐ Day ☐ Night ☐ Intermittent

Please provide details (type of equipment/settings/instructions for use):

Has the camper had a tracheostomy? ☐ Yes ☐ No

If yes, please explain current needs:

Please provide or arrange for your own oxygen equipment to be delivered to camp for the camper's use. If you need assistance, please contact the medical team at 419-751-7077.

MEDICAL BACKGROUND

☐ *See attached medical records*

Does the camper have any specific dietary restrictions (soft, mashed foods, tube feeds, etc.)? ☐ Yes ☐ No

If yes, please explain the restrictions:

Does the camper have any specific care requirements (dressing changes, nasal irrigation, eye care, taping eyelids shut, etc.)? ☐ Yes ☐ No

If yes, please explain the requirements:

Does the camper have any of the following impairments? ☐ Hearing ☐ Speech ☐ Vision

Does the camper utilize any assistive devices?

Comments:

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:

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.

Any additional comments:

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.

Any additional comments:

Form filled out by: _____
(must be completed by a physician or advanced practice provider)

Provider's signature: _____

Date: _____

Hospital/Affiliation: _____

Email: _____

Office Phone: _____

Office Fax: _____