

2024 SICKLE CELL MEDICAL FORM



a seriousfun camp

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: _____

Hemoglobinopathy Diagnosis (SS, SC, S-thal, other): _____

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			

MEDICAL BACKGROUND

Has the camper been hospitalized in the past year? Yes No

If yes, please include dates: _____

Has the camper ever been in the intensive care unit? Yes No

If yes, approximate date(s) and description(s): _____

Has the camper had complications related to their disease? Yes No

If yes, please describe and include dates:

	Acute Chest Syndrome	
	Stroke	
	Aseptic Necrosis	
	Splenic Sequestration	
	Priapism	
	Bacteremia/Infection	
	Gallstones	
	Sleep Apnea	
	Hip/Pain Problems	
	Asthma	
	Other (describe):	

Treatment:

Does the camper have a history of PICA? Yes No

If yes, please describe:

Does the camper have splenomegaly? Yes No Size: _____

Is this camper on a chronic transfusion protocol? Yes No

If yes, please include protocol/pretreatment protocol and history of reactions:

Date of most recent transfusion:

If available, please provide the most recent or baseline labs:

Date drawn:

H/H:

Reticulocyte Count:

WBC:

PSYCHOSOCIAL INFORMATION

See attached medical records

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

<input type="checkbox"/>	ADD/ADHD
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Autism Spectrum Disorder
<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Developmental Delays
<input type="checkbox"/>	Mood Disorder
<input type="checkbox"/>	Obsessive Compulsive Disorder

<input type="checkbox"/>	Oppositional Defiance Disorder
<input type="checkbox"/>	PICA
<input type="checkbox"/>	Post Traumatic Stress Disorder
<input type="checkbox"/>	Reactive Attachment Disorder
<input type="checkbox"/>	Other (please specify):
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

MEDICAL ACTION PLAN – Please fully complete this section.

What are the early warning signs and symptoms that your camper may experience a crisis? _____

Pain Crisis Triggers: Cold Heat Other: (specify) _____

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

What medication does the camper take for:

<input type="checkbox"/>	Mild Pain:	
<input type="checkbox"/>	Moderate (increasing pain):	
<input type="checkbox"/>	Severe Pain:	

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: _____