2025 SICKLE CELL 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: _____

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 *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:

☐	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 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:

☐	Mild Pain:	
☐	Moderate (increasing pain):	
☐	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 if no restrictions necessary or detail restrictions in the box below.

☐ No activity restrictions necessary.

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.

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: _____