

## 2026 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.***

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

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### **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: \_\_\_\_\_