2025 TRANSPLANT 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: ______________________________

Type of transplant: *(please include date)* ______________________________

Reason for transplant: ______________________________

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			

MEDICAL BACKGROUND

Has the camper ever had a rejection episode? ☐ Yes ☐ No

If yes, when and please describe symptoms: ______________________

Does the camper have any tubes or lines? ☐ Yes ☐ No

If yes, describe what they are used for: ______________________

OTHER DIAGNOSES

Please check if the camper has/had any of the following.

☐ Hepatitis B ☐ Hepatitis C ☐ Autoimmune Hepatitis

☐ HIV ☐ Seizures ☐ TB

☐ Other (specify) ______________________________

COMPLICATIONS

Please check if the camper has/had any of the following.

	PTLD
	Hyperlipidemia
	CMV Disease
	Acute Cellular Rejection
	Chronic Rejection
	Hypertension

	Renal Insufficiency
	Enuresis
	HAT/PVT/Biliary Complications
	At risk for bleeding
	Splenomegaly >2 cm below LCM
	Transplant < 1 year from attendance at camp

Anticoagulants: ☐ Yes ☐ No — If yes, type: ☐ ASA ☐ Coumadin ☐ Other ________________

Diabetes: ☐ Yes ☐ No — If yes, insulin dependent: ☐ Yes ☐ No

Endocrinologist: ______________________________

Please provide BP parameters: Call for BP greater than ________________ or less than ________________

Does this child require labs while at camp? ☐ Yes ☐ No

If yes, please list labs and dates needed: ______________________________

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 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: ______________________________