

## 2026 TRANSPLANT 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: \_\_\_\_\_

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.

|                          |                          |
|--------------------------|--------------------------|
| <input type="checkbox"/> | PTLD                     |
| <input type="checkbox"/> | Hyperlipidemia           |
| <input type="checkbox"/> | CMV Disease              |
| <input type="checkbox"/> | Acute Cellular Rejection |
| <input type="checkbox"/> | Chronic Rejection        |
| <input type="checkbox"/> | Hypertension             |

|                          |   |
|--------------------------|---|
| <input type="checkbox"/> | Renal Insufficiency                         |
| <input type="checkbox"/> | Enuresis                                    |
| <input type="checkbox"/> | HAT/PVT/Biliary Complications               |
| <input type="checkbox"/> | At risk for bleeding                        |
| <input type="checkbox"/> | Splenomegaly >2 cm below LCM                |
| <input type="checkbox"/> | 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:

|                          |                               |
|--------------------------|-------------------------------|
| <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/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: \_\_\_\_\_