

Camper Name: _____

Birthdate: _____



a serious fun camp

ONCOLOGY FORM

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

This form, in addition to the Physical Exam form, must be completed by the medical specialist for all applicants.

Oncologist _____ Day Phone _____ After-Hours Phone _____

Address _____ Email _____

Hospital (where child is treated): _____ Nurse/Coordinator: _____

Oncology Diagnosis: _____ Date of Dx: _____

Secondary Diagnoses: _____

Date of relapse (if applicable) _____

Has the child had a stemcell transplant? No Yes Date: _____

Is the child still on treatment? No Yes *If No, date chemotherapy was completed:* _____

If Yes, please give details of the chemotherapy including dates and meds: _____

Does the child have any pertinent long term side effects from his or her treatment or disease that camp should be aware of?

No Yes

If Yes, please explain: _____

Does the child *regularly* receive lab work? No Yes *If yes, please provide details or a copy of most recent labs:*

Will child require labs while at camp? No Yes *If yes, please list labs and date needed:*

Additional comments: _____

Please attach most recent clinic note

Physician Name (Print)

Signature

Date

Completed by (Print Name)

Signature

Date