



11615 Hesby St.
 N. Hollywood, CA 91601
 (818) 754 0312
 (818) 754 0377 fax
 www.campdelcorazon.org

Camper Cardiology and Medical Form

To be completed and returned to the camp office, along with the online parent application.

Dear Parents, please complete the following Medical Information Release:

I hereby authorize release of the information requested on this form to Camp del Corazon, it's delegates and other medical care providers that they deem appropriate and necessary.

Camper Name: _____ **Parent/Legal Guardian (print):** _____

Signature of parent or legal guardian X _____

Dear Pediatric Cardiologist,

Your patient is applying to attend Camp del Corazon! Your cooperation is requested to provide our medical staff with pertinent medical history about your patient. This form is to be completed by the Pediatric Cardiologist or an Approved Nurse. **We also offer a simple, secure online Cardiology Form for your convenience. Please email alyx@campdelcorazon.org for details.** All information is confidential and solely for the guidance of the Camp del Corazon medical staff. Please use information from the most recent visit (within the last 12 months) in completing this form. Please return the form to camp as soon as possible via fax at **(818) 754-0377**, or by mail, as our medical staff needs to review it before this camper can be accepted.

Thank you for your help in facilitating your patient's fun-filled summer at camp!
 -The Camp del Corazon Staff

Patient Information

Patient Name: _____ **Age:** _____ **Sex:** _____ **D.O.B.** ____/____/____

Cardiac Diagnosis

PLEASE print or type. Medical staff must be able to CLEARLY read the diagnosis. This is vital to our programming and staffing. (You may include a dictated note if helpful.)

<u>Cardiac Diagnosis</u>	<u>Procedures Performed</u>	<u>Date</u>

Physical Exam

Height: _____ cm Weight: _____ kg H.R.: _____ B.P.: _____

SaO₂ saturation range _____

Neurologic: _____ Lungs: _____

Cardiovascular: _____ Precordial activity: _____ Murmurs: _____

Pulses: RUE _____ LUE _____ RLE _____ LLE _____

Abdomen: _____ GI/GU: _____

Allergies

<u>Medication/Trigger</u>	<u>Date of Last Reaction</u>	<u>Type of Reaction</u>

Does your patient carry an EpiPen? Yes No

Prescribed Medication

(Please be specific)

<u>Type of Medication</u>	<u>Dosage</u>	<u>Frequency</u>

PLEASE NOTE ANY SPECIAL INSTRUCTION FOR ANY OF THE ABOVE LISTED MEDICATIONS:

(i.e. Refrigerate, take pulse prior to giving, watch for bleeding, or history of seizures)

High Risk Medications

Is the patient taking anticoagulation medication? Yes No

Please describe: _____

Recommended Sub - Acute Bacterial Endocarditis Prophylaxis

- None Standard Amoxicillin Regimen
 Erythromycin Other: _____

Cardiac Rhythm/Device History

Does applicant have a history of dysrhythmia? Yes No Please describe: _____

Date of last episode: ____/____/____

Has there been any recent cardiac concern / medical event? _____

Does applicant have a PACEMAKER or ICD? Yes No

If yes, select device type: Pacemaker ICD

Manufacturer: _____

Reason for implantable device: _____

Date of insertion: ____/____/____ Date of Last Interrogation: ____/____/____

Lower Rate: _____ Indication: _____

Has ICD discharged recently? Yes No How often? _____

Cardiac Transplant Only

Date of Transplant: ____/____/____ Surgeon: _____

Name of Center: _____ Phone: ____-____-____

Any recent events? _____

Pulmonary Hypertension

Is there a diagnosis of pulmonary hypertension for your patient? Yes No

Is your patient on an IV medication? Yes No

Is your patient taking an inhaled medication? Yes No

Non-Cardiac Diagnoses & Behavioral Information

Describe non-cardiac diagnoses and any treatment or surgery you are aware of: _____

Describe any behavioral concerns you think could impact this patient's participation: _____

Activity Participation

Does applicant participate in a physical education program at school? Yes No

Please **circle** one of the letters below describing the level of activity at which the applicant is able to participate.

- A) **FULL ACTIVE PARTICIPATION WITH MODERATE EXERCISE**
Participates in non-competitive games, which may involve running short distances.

- B) **PARTIAL ACTIVE PARTICIPATION WITH LIGHT EXERCISE**
Participates in limited activities. Camper rests occasionally.

- C) **LIMITED ACTIVE PARTICIPATION WITH NO EXERCISE**
Must rest frequently and often. May participate in sedentary activities only.

If applicant fits **category C**, please reconsider his/her suitability for camp. If you perceive that this applicant may benefit from actively participating in our programs, please submit a written explanation.

Is there anything else we should know? _____

Doctor's Statement

Thank you for helping us make Camp del Corazon a safe place for children with heart disease. If any event occurs while your patient is at camp we will contact you as soon as possible as instructed below:

I have examined _____ who is physically able to engage in camp activities, except for the limitations and restrictions listed above.

Physician's Signature: _____

Print Name: _____ Date: ____/____/____

Address: _____

Hospital Affiliation: _____

Phone Numbers: Office ____-____-____ Off Hours On-Call ____-____-____

Some of my other patients may benefit from attending Camp del Corazon. Please send me a few brochures.

**Camp del Corazon
11615 Hesby Street
North Hollywood, CA 91601**

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