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 herby authorize release of the information requested on this form to Camp del Corazon, its 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.____/____/_____

Date of Last Visit: __________________________

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.)

Cardiac Diagnosis	Procedures Performed	Date

Physical Exam

Height:________cm Weight:____________kg H.R.:______________ B.P.:________________

SaO_2 saturation range______________________________

Neurologic:_______________________________________ Lungs:______________________________________

Cardiovascular:____________________Precordial activity: ___________________Murmurs:__________________

Pulses: RUE________________LUE_____________RLE____________________LLE_____________________

Abdomen:_____________________________________ GI/GU:____

Allergies

Medication/Trigger	**Date of Last Reaction**	**Type of Reaction**

Does your patient carry an EpiPen? □Yes □No

Prescribed Medication

(Please be specific)

Type of Medication	**Dosage**	**Frequency**

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 Corazaon. Please send me a few brochures.

Camp del Corazon
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