Pennsylvania Division, Inc.

2006 CAMP CAN-DO
Application / Medical Assessment

All information must be completed and returned by May 26, 2006

Please Note: **All Campers Must Meet The Following Criteria**

1. Be between the ages of 8 and 17
2. Must have had cancer / treatment after their fifth birthday
3. Cannot have been off treatment for more than 5 years
4. Special needs, in addition to cancer / treatment, will be considered on a case-by-case basis.
5. All paperwork must be completed in full and returned by May 26th.

For which camp are you applying? July 30 – August 5, 2006 August 6 - 12, 2006

(Each Camp Will Have A Limit Of Campers On First-Come, First Served Basis)

CAMPER INFORMATION

(All information will be kept strictly confidential)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Email: _____

What age will you be in August? _____ Date of Birth: _____

Height: _____ Weight: _____

Allergies/Reactions: _____

_____

Primary language spoken:_____ Male / Female (Circle One)

T-Shirt Size (adult sizes): Small Medium Large X-Large

Please send copy of Child's Health Insurance and Prescription coverage card(s) with this application.

TO BE COMPLETED BY PARENT OR GUARDIAN

Hospital where you receive(d) treatment: _____

Physician Name: _____

Parent or Guardian's Name: _____

Address (if different from camper's): _____

City : _____ State: _____ Zip: _____

Day Phone: _____ Evening Phone: _____

Cell Phone: _____ Fax #: _____

Campers (or parent's) Social Security Number: _____

Has your child ever had a problem with any of the following?

	Yes	**No**		**Yes**	**No**
Bedwetting	_____	_____	Dressing Self	_____	_____
Eating	_____	_____	Nightmares	_____	_____
Following Instructions	_____	_____	Sleepwalking	_____	_____
Personal Hygiene (washing, brushing teeth, etc.)	_____	_____	Getting along with other children	_____	_____

Other problems: _____

_____

_____

(Parent or Guardian's Signature)

In addition to the physician completing page 3, your child will be required to bring the Medical Update Form with them to camp. This form will be part of a later mailing.

Camp Can-Do
Preliminary Medical History Form
(To Be Completed by Camper's Physician)

Camper Name: _____

Primary Diagnosis: _____

Medical History (including surgery): _____

_____

_____

Date of Diagnosis: _____

Date of last treatment:_____ (REQUIRED)

Immunizations: _____

_____

Primary Physician at the Center: _____

Phone # at the Center: _____

Does camper have any physical restrictions? Yes_____ No_____

If yes, please specify: _____

Allergies/reactions: _____

Devices: ***Circle one*** glasses contacts hearing aid prosthesis

IV Access: ***Circle one*** Broviac/Hickman Port/Pasport PICC none

Special Equipment (i.e., crutches, walker, etc.): _____

Blood Product Transfusions and Special Handling/Pre-medications: _____

_____

Medications:

Name	**Dosage**	**Frequency**	**Special Instructions**

Physician's Signature:_____ Date: _____

(Campers *will not* be accepted without Physician Signature)