



Camp Kydnie

A special camp for kids with kidney disease

MEDICAL HISTORY FORM FOR ALL CAMPERS

INSTRUCTIONS: ALL CAMPERS (Kydnie Kids, siblings and friends) must provide a completed medical history form to attend camp. This form must be completed by the camper's health care provider and must include health care provider signature on the reverse.

Dialysis campers must have been examined by their physician within 12 weeks of camp, other kidney campers within 6 months, and siblings and friends within 1 year.

Please note that both sides of this form must be completed and **signed by the camper's medical provider**. Please return this form with the camper application or as soon as completed by physician.

PARENTS OF DIALYSIS CAMPERS MUST CONTACT THE CAMP DIRECTOR, DEVON NORDINE, AT 717-418-9629 TO ENSURE THAT APPROPRIATE DIALYSIS ARRANGEMENTS CAN BE MADE. ADDITIONAL INFORMATION, INCLUDING A SUPPLEMENTAL DIALYSIS MEDICAL FORM, WILL BE REQUESTED AT THAT TIME.

Camper's Name: _____ DOB: _____

Weight (kg) _____ Height _____ BP _____

Allergies (list allergen and reaction) _____

Medical Concerns:

Please list all current and chronic medical problems. Include renal diagnoses and current creatinine for Kydnie Kids. If necessary, please attach additional pages.

Current serum creatinine _____ Date _____

Mental Health Concerns:

Please list all current and chronic mental health, behavioral and/or developmental diagnoses or concerns (such as ADHD, depression, ADD, anxiety, Asperger's syndrome or autism or need for wrap-around services.) Health care providers – please consider what information you would need to know if you were responsible for this child's emotional and medical care at camp. If necessary, please attach additional pages.

For campers with Mental Health/Behavior concerns including requiring wrap-around services, please contact the Camp Medical Director – Dr. Sabeen Habib, 717-531-5707 (Penn State Hershey Children's Hospital, Pediatric Nephrology)

Immunizations:

Please include an up-to-date copy of the camper's immunization record card with this form.

Current Medications

Please include an up-to-date copy of the camper's current medication list with this form. The list should include the name of the medication, dosing schedule, and how taken.

Examples: Enalapril, 5 mg tablet, twice daily at breakfast and bedtime, by mouth
Nutropin, 1.5 mg injection, subcutaneously, once weekly, on Thursday evenings

FOR ALL CAMPERS, PLEASE ALSO COMPLETE THE INFORMATION ON THE REVERSE PAGE

CAMP KYDNIE – ALL CAMPER MEDICAL HISTORY FORM PAGE 2

Does the camper have any dietary restrictions or special dietary requirements? Please include requirements for any form of tube feedings or dietary supplements. Please list:

Does the camper have any fluid restriction or specific fluid requirement? Please list:

ADDITIONAL MEDICAL INFORMATION FOR KYDNIE KIDS

1. Please include information about recent hospitalizations or any significant recent illness. Please attach additional pages if necessary.

2. Does the camper require any form of urinary catheterization? Please include schedule and technique (for example, clean or sterile, urethral catheterization or via an ostomy.) Is the camper independent with catheterization, or do they require assistance or supervision?

Please be sure to send an adequate supply of catheters and any other necessary supplies with your camper.

3. Does the camper have a central line, hemodialysis catheter or peritoneal dialysis catheter: _____

If yes: What type and location: _____

How often is it flushed: _____

What heparin solution/dose is used? _____

Is your camper allowed to swim? (chlorinated pool only) _____

If yes, what do you use to cover the catheter when the child swims? _____

Please be sure to send sufficient supplies for dressing changes and other line care to camp. Note that with increased activity at camp, extra dressing changes are often necessary.

4. Does the camper require dialysis? _____ Type: Peritoneal Dialysis _____ Hemodialysis _____

PARENTS OF DIALYSIS CAMPERS MUST CONTACT THE CAMP DIRECTOR, DEVON NORDINE, AT 717-418-9629, TO ENSURE THAT APPROPRIATE ARRANGEMENTS ARE MADE.

Health care provider: Please list any additional pertinent information, precautions or restrictions for this patient:

I examined _____ on _____ and found him/her to be in good health and able to attend camp.

Provider signature: _____ Date: _____

Provider name (please print) _____ Office phone: _____