***This page is Required for patients ON treatment only**

THIS PAGE IS TO BE COMPLETED BY **Physician, Physician's Assistant (PA) or Nurse Practitioner (NP) Physician/PNP**

On Treatment Form - Recommendations and Restrictions at Camp

I examined _____ _____

camper's full name DOB

on_____.

Date of most recent examination

Weight _____ Height_____ BP_____

Last blood count : Date _____ Hgb _____ Hct_____

WBC _____Platelets_____

Differential or ANC _____Varicella Titer_____

Current physical and medical condition:

Current chemotherapy. Please include a copy of current chemotherapy roadmap or regimen.

Any medically-prescribed meal plan or dietary restrictions:

Description of any limitation, concern or restriction on camp activities

I hereby verify that the information on the above form and preceding forms concerning health matters and medications is correct. In my opinion, this child is able to participate in Camp CARE.

Signature of Physician/Practitioner_____

Print Name _____ Date_____