



Big Sky Kids 2010

Medical Release & Information

Medical staff is at camp 24 hours a day for the duration of camp. In addition, we are located approximately 40 minutes - 1 hour from Bozeman Deaconess Hospital. During the Young Adult Retreat, we maintain contact with medical centers as we travel.

This release is for all Big Sky Kids events in 2010 including: Spring Fling- March 19-21, Camp Braveheart- July 21-25, Big Sky Adventure- June 23-July 2, and Young Adult Retreat- August 10-18.

Activities may include: fishing, horseback riding, hiking, motor-boating, rafting, kayaking, camping, swimming, backcountry camping, skiing, snowboarding, cross-country skiing, snowshoeing, light sports and games (indicate if contact must be restricted), indoor rock climbing

NAME: _____ **AGE:** ____ **BIRTHDATE:** _____, my patient, has received a medical evaluation, and I hereby give my permission for his/her participation in Eagle Mount's Big Sky Kids camps.

The following activities should be restricted: _____

MEDICAL INFORMATION REGARDING THIS PATIENT

Diagnosis: _____

If a solid tumor, please list location and stage at diagnosis: _____

Treatment Protocol: _____

Any relapses? If yes, please list date(s) and location(s). _____

Bone marrow transplant? No Autologous Transplant Allogeneic Transplant Date _____

Please outline a brief but comprehensive medical overview/summary of the patient's condition and treatment course to date. We mainly want to know about important surgeries, dates of chemotherapy, dates and location of radiation, episodes of serious infections, prolonged hospitalizations, etc. so that we can best prepare for a safe camping experience:

Please list any other relevant information that our medical staff should know about: _____

Is the patient currently under active treatment? Yes No. If yes, when will his/her last treatment take place and what chemotherapy do you expect him/her to be given that cycle? _____

What chemotherapy drugs has the patient been treated with over the course of his/her illness? (Check all that apply.)

- | | | |
|--|---|---|
| <input type="checkbox"/> 6-Mercaptopurine (6-MP) | <input type="checkbox"/> Cyclophosphamide or Ifosfamide | <input type="checkbox"/> Retinoic Acid (cis-RA or ATRA) |
| <input type="checkbox"/> 6-Thioguanine (6-TG) | <input type="checkbox"/> Doxorubicin (Adriamycin) or Daunorubicin | <input type="checkbox"/> Steroids (Prednisone, Dexamethasone) |
| <input type="checkbox"/> Ara-C (Cytarabine) | <input type="checkbox"/> Etoposide (VP-16) | <input type="checkbox"/> Temozolomide (Temodar) |
| <input type="checkbox"/> Asparaginase | <input type="checkbox"/> Irinotecan or Topotecan | <input type="checkbox"/> Vinblastine |
| <input type="checkbox"/> Bleomycin | <input type="checkbox"/> Methotrexate | <input type="checkbox"/> Vincristine (Oncovin) |

Does the patient have any of the following symptoms? (Check all that apply.)

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergic to bee stings | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures, spells or epilepsy |
| <input type="checkbox"/> Balance problems (falls easily) | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Body parts sensitive to heat, cold, or impact | <input type="checkbox"/> Heartburn or Acid Reflux (GERD) | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Constipation or encopresis | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Sleepwalking |
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Stomachaches or cramps |
| <input type="checkbox"/> Depression or anxiety | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Temper tantrums or anger episodes |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Tendency to bruise or bleed easily |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea and/or vomiting | <input type="checkbox"/> Uses wheelchair/walker/crutches/cane |
| <input type="checkbox"/> Difficulty with coordination | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pain | <input type="checkbox"/> Weak bones or joint problems |
| <input type="checkbox"/> Emotional lability (mood swings) | <input type="checkbox"/> Picky eater | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Wears braces or prosthetic |
| <input type="checkbox"/> Gets tired easily | | <input type="checkbox"/> Wetting the bed at night |

Please describe and explain any checked symptoms, including any inciting factors, location of symptom, and the treatment approach that you have found to be most useful to help the patient. Also, parents, please make sure to bring or send any "as needed" medications (albuterol inhaler, pain medications, Epi-pen, antacids, etc.) to camp in case they are needed.

Medication Allergies (List each drug and describe the allergic symptoms.): _____

Other Allergies (List each and describe the allergic symptoms.): _____

Are there any over-the-counter medications contraindicated for this camper? _____

Current Medications (Please bring all your medication to camp in or with labeled pharmaceutical containers. Have ready upon arrival for check-in with camp nurse. At camps and retreats where parents or guardians are in attendance, you will administer your child's medications. It is, however, still important for our medical staff to have this information, so please be thorough.)

Oral Medications: (Please list each medication separately along with dosage and frequency.)

Injectable Medications: (Please list each medication separately along with dosage and frequency.)

Do you anticipate that the patient's blood counts will be normal or abnormal (low) for camp?

If the patient gets a fever, does he/she usually require blood work and/or antibiotics? Yes No _____

To the best of my knowledge, the above information is true and correct. To my knowledge, there is NO REASON why this person cannot participate in these supervised recreational camps, with the exception of restricted activities noted above. Should any medical emergency arise during this activity, I have provided telephone numbers where I may be reached for medical consultation concerning the welfare of my patient.

Physician's Name (Print or Type) _____

Address _____

Emergency Phone: Office _____ Home _____

Hospital _____ Hospital Phone _____

Signature _____ Date _____

Thank you for completing this information. It will help our staff and volunteer medical staff to provide a quality camp experience for your patient.

...They shall mount up with wings as eagles. ISAIAH 40:31
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