

MEDICAL INFORMATION

To be completed by Physician

NAME: _____

Check One: Male Female DOB: _____ Age: _____

Medical Information:

HD CAPD CCPD

Start date of modality: _____

Underlying renal disease:

Transplant Date: _____

Rejection Episode: **NO YES**

Current Problems: **NO YES**

If YES, describe: _____

Transplant labwork to be drawn at camp?: **NO YES, describe**

Other active medical problems: seizures, diabetes, hypertension: **NO** **Yes, describe:** _____

Drug Allergies: **NO YES, describe** _____

Food Allergies: **NO** **YES, describe** _____

Routine vital signs during camp: Wt, BP, Temp & how often: **NO** **YES, describe:** _____

Special medical needs: ostomy care, dietary or fluid restrictions, NG/NT feeds, incontinence, symptomatic hyper/hypo tension: **NO** **YES, describe:** _____

_____ self: **NO Yes**

intermittent catheterization: **NO Yes, frequency:** _____

Restricted activities: swimming, horseback riding, sun exposure: **NO YES, describe** _____

Any behavior problems/ family problems: **No** **Yes, describe:** _____

Recent labs (please date):

H/H K PO4 CA BUN/Creat

All the above information is correct:

MD Signature: _____ Print Full

Name: _____

Facility: _____

Phone: _____ FAX: _____

Primary

Nurse: _____ Phone: _____

Social Worker: _____

Phone: _____