Camper Medical Provider Form
To be completed by a Medical Professional Only

Dear Medical Provider,
Your patient (listed below) has applied to attend camp at National Kidney Foundation of Arizona's Camp Kindey. In order to consider their application we need **ALL** of the following information completed:

1. **Camper Medical Provider Form (page 1)**
2. **A copy of the child's most recent progress notes or hospital discharge note**
3. **Physicians Clearance for Activities (page 2)-** for campers with a cardiac condition, please have the cardiologist give diagnosis and clearance for activities
4. At this time, we cannot accommodate campers with home vents, CPAP, BiPAP, tracheostomies, or home oxygen.

Please return all completed forms to:
Email: camp@azkidney.org or **Fax**: (602) 845-7967
If there are any questions about this form or camper, please feel free to contact NKF AZ at (602) 840-1644.

Camper Name: _____ Date of Birth: _____

Parent Name and Phone #: _____ Diagnosis: _____

Significant past medical history/other medical conditions:

☐ Yes ☐ No Is the child developmentally appropriate for their age ? If no, at what (approximate) age does child function? _____

List any communication problems, pertinent psychosocial information, or behavioral problems that would affect the child's participation in a group: _____

Infection Control:

Yes No **Live vaccines deferred?** **If yes, explain why:** _____

☐ Yes ☐ No **To the best of your knowledge, has this child ever tested positive for** ☐ MRSA ☐ VRE

If yes, date cleared _____ **We cannot accept these campers unless infection has been cleared.**

☐ Yes ☐ No Has the child had recurrent outbreaks of shingles? If yes, please indicate frequency in the past 12 months _____

☐ Yes ☐ No Special Infection Control Precaution : If yes, please explain _____

Devices

☐ PD Catheter ☐ HD Catheter *(If yes, please complete Supplemental Dialysis Form.)*

☐ Central venous line/Port-a-cath Type _____ Location _____

☐ Bile Tube ☐ G-tube ☐ GJ-tube ☐ J-Pouch ☐ Ostomy ☐ Insulin Pump ☐ Baclofen Pump

☐ Hearing Aids ☐ PE Tubes ☐ Glasses/Contacts ☐ Spinal Rods ☐ VNS ☐ VP Shunt ☐ Other _____

☐ AFO ☐ Other Mobility Device(s) _____

Bladder/Bowel Treatment Program:

☐ Needs urinary catheterization Cath Size: _____ Every (hrs): _____ Site of catheterization: ☐ Mitrofanoff ☐ Urethra

☐ Malone/ ACE ACE Irrigation # of times a day: ☐ Volume (in cc) ☐ ☐ Normal Saline ☐ Other ☐

☐ Enema ☐ Suppository ☐ Medication Any Additional Instructions: ☐

Dietary

☐ Yes ☐ No Food Restrictions/Special Diet: If yes, please explain: ☐

G Tube

Formula

- ☐ YES
- ☐ NO

If yes, type of Formula: _____

Daytime boluses _____mL, times given: _____, _____, _____

Nighttime drip _____mL, for _____ hours

Water drip

- ☐ YES
- ☐ NO

If yes, _____mL, for _____hours

PHYSICIAN CLEARANCE FOR ACTIVITIES

Dear Health Care Provider:

Your patient _____ , DOB _____ has applied to Camp Kidney and is interested in participating in activities which may be contraindicated by the child's medical condition. In order to safely provide these activities, The Painted Turtle requests that you review the following evaluation of medical precautions and contraindications and indicate if your patient has any of the contraindications. All activities are supervised by Camp Kidney staff. Each camper is also evaluated by a trained activity professional for fitness to participate.

Horses

- All campers wear helmets
- Horses are led by an equestrian specialist and have at least one side walker at all times

Contraindications to our horse program may include: (check any that apply)

☐ Spinal Stenosis ☐ Atlantoaxial Instability ☐ Cervical Spine Instability

☐ Hip Joint Subluxation or Dislocation ☐ Weight over 180 pounds

Precautions to the horse program (child may be able to participate based on frequency and type of seizures):

Seizure Type: _____ Frequency: _____ Date of last seizure: _____

Additional comments or concerns:

_____

Ropes and Climbing Wall

- All campers wear helmets and waist harness
- Chest harnesses are used for all campers on ropes course
- Ropes course is accessible for campers who use wheelchairs and/or walkers

Contraindications to ropes and climbing wall program : (check all that apply)

☐ Symptomatic Spinal Stenosis ☐ Atlantoaxial Instability ☐ Chiari Type II

Additional comments or concerns:

_____

I have read the contraindications and precautions and my patient has the following medical conditions:

_____

Physician's Signature: _____ Date: _____ Phone # for questions: _____

Supplemental Kidney Medical Form
Must be completed by a Nephrologist Only

Dear Medical Provider,
The camper listed below has applied to attend camp at National Kidney Foundation of Arizona's Camp Kidney. In order to consider their application we need the following information completed and returned to NKF AZ as soon as possible.

Please return all completed forms to:
Email: camp@azkidney.org
Fax: 602.840.2360
If there are any questions about this form or camper, please feel free to contact NKF AZ at (602) 840-1644.

Camper Name: _____ DOB _____ Child's Weight (kg): _____

Renal Information

Date camper was last seen by medical team: _____ Primary Renal Diagnosis: _____

Most Recent Lab values:

****** Labs will need to be checked again before camp within:**

- **Six (6) months of camp for General Nephrology campers**
- **One month of camp for Post Transplant campers if transplant within last 6 months; within 3 months of camp if transplant >6 months before camp.**
- **Two Weeks of camp for Hemodialysis and Peritoneal Dialysis campers**

Most **recent laboratory values:** Date labs drawn _____ (May attach a lab result summary)

Hgb _____ Hct _____ Cr _____ BUN Pre _____ BUN Post _____ K _____ CO2 _____ Ca _____ PO4 _____ Na _____

*****Please attached most recent clinic note and/or discharge summary.*****

Transplant Information (Complete if applies to the camper listed above)

Date of Transplant: _____ Secondary Condition(s): _____

Rejection episode in past 6 months: ☐ Yes ☐ No If yes, date and treatment _____

Is camper a multi organ transplant (i.e. kidney + heart or liver)? ☐ Yes ☐ No

_____

Physician's Signature: _____ Date: _____

Peritoneal Dialysis Information Form (If applicable)

Camper Name: DOB

Peritoneal Dialysis Information

☐ CAPD ☐ CCPD Date started dialysis: Is child anephric? Yes ☐ No ☐ Child's Dry Weight (kg):

Dialysis Unit Name: Phone Fax

Name of Cycler: Name of Catheter Cap:

Fill Vol (cc) Dwell time (hours) # exchanges/cycles Total Vol

Total Number of Hours/Night Last Fill Vol Dextrose Concentration Used

Mid-day exchange: Yes ☐ No ☐ Exchange will be around 2:00pm Volume (cc): % Dextrose

Low Ca + Dialysate Regular Ca + Dialysate 3L bags (PD-2) 6L bags (Low Calcium)

Other:

Inflow/Outflow problems:

Infection History (within last six months):

Peritonitis:	Date:		Organism(s):		Treatment:	
Exit Site:	Date:		Organism(s):		Treatment:	
Tunnel:	Date:		Organism(s):		Treatment:	

Fluid Choice Parameters (Weight or Blood Pressure)

If wt/bp < _____, use _____

If _____<wt/BP > _____, use _____

If wt/bp > _____, use _____

2018 CAMP KIDNEY PERITONEAL DIALYSIS ADDENDIUM

To help facilitate the adolescents (older than >12yrs old) being able to participate in all evening activities, we recommend changing their dialysis prescription to 8hrs overnight with a daytime exchange (or add a 2nd daytime exchange if already on high volume dialysis). Default daytime exchanges will be scheduled around 2pm; 2nd daytime exchange, if necessary, will be before dinner. The younger children will remain on their prescribed dialysis prescription.

Do you feel that it will be appropriate for this camper to change his/her prescription while he/she is at camp?
_____ Yes _____ No

If yes, please provide preferred prescription: **(total time 8 hours overnight)**
Fill Volume _____ Last Fill Volume_____ Total Volume _____
Number of Cycles _____
Daytime Exchange Volume: _____
Notes: