PLEASE PRINT THIS SECTION AND GIVE IT TO YOUR

Physician, NP or PA

Must be signed for attendance

HISTORY AND PHYSICAL FORM

To be filled out by the Camper's Physician / NP / PA and returned to the Dream Street office.

Camper Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone ( ) _____

Primary Medical Diagnosis: _____

_____

Secondary Diagnosis: _____

_____

Date of Initial Diagnosis: _____

Date of Subsequent Relapse or Recurrence: _____

_____

Therapy given for primary medical problem:

- Length of therapy (start and stop dates): _____

PLEASE INCLUDE COPY OF ROAD MAP IF APPLICABLE

- Surgery for the primary medical problem? _____

Does your patient have a Central Venous Access device? _____

If yes, type of device: ☐ **Port** ☐ **PICC** ☐ **CVL**

Allergies to medications: _____

_____

Allergies to foods/environmental: _____

_____

Does your patient have any behavioral problems? ____ Yes ____ No

☐ AD(H)D ☐ Oppositional ☐ Eating Disorder Other _____

If yes, please explain _____

_____

PHYSICAL EXAMINATION / MEDICAL INFORMATION

Camper's Name: _____

Date of examination: _____

Vital Signs: Ht _____ in/cm Wt _____ lb/kg BP _____ HR _____ RR _____

Has child had any infections with resistant organisms? ☐ Yes ☐ No

If yes, Please explain:_____

☐ **Checklist Mandatory: Check if Normal, or give details of abnormalities below.**

☐ HEENTN: _____

_____

☐ Respiratory: _____

_____

☐ Cardiovascular: _____

_____

☐ Gastrointestinal/Renal: _____

_____

☐ Musculoskeletal: _____

_____

☐ Neurological: _____

_____

☐ Skin: _____

_____

☐ Genitalia/Rectum: _____

_____

Date of last transfusion (if within last 6 months): _____.

If transfusion dependent, Date of transfusion prior to the beginning of camp: _____.

Special Diet (specify): _____

If this child has Seizures, specify frequency _____ type _____

and how seizures should be handled at camp: _____

Date of laboratory test:

WBC _____ Hgb/Hct _____ Platelets _____ Differential _____

History of Chickenpox/vaccine? _____ Tetanus Vaccine _____

PATIENT'S NAME: _____

Please list child's regular and occasional medicines below. Include the name of the drug, the dosage, how often it is taken and if there are any special times the drug should be taken.

These are your medication orders for the week of camp.

Current Medication	Route	Exact Dosage patient receives	Frequency	Times

I have examined the person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted.

SIGNATURE OF EXAMINING MD / NP / PA _____

Please print name _____

License number _____ Address _____

City _____ State _____ Zip _____

Phone _____ Date _____

For those with any hematology/oncology disorders - a CBC with differential and platelet count is required 12 days prior to camp. The physical exam should be performed within 2 months of arrival at camp. Examination for some other purpose within this period is acceptable.

Please return to:
Dream Street
324 SOUTH BEVERLY DRIVE, SUITE 500 • BEVERLY HILLS, CALIFORNIA 90212

Email: DreamStreetCA@gmail.com
Fax 310-388-0302

PHYSICIAN ORDER SHEET

CAMPER'S NAME: _____

All orders will be reviewed prior to the camper arriving for the Dream Street session. All laboratory results and medical incidents involving your patient will be communicated to you either by phone, by medical report or both, depending upon the acuity of the values or event.

If you have any questions or need to clarify the therapy that your patient will need during the camping session, you may contact either:

- **JENNIFER HUSON, RN, MSN, CPNP, CNS** Nursing Director, Dream Street Foundation
  Phone: Dream Street office **424-333-1371**
- **EVAN KOURSH, MD,** Medical Director, Dream Street Foundation
  Phone: Dream Street office **424-333-1371**
- **DREAMSTREETCA@GMAIL.COM**

ORDERS:

Days M_ T_ W_ TH_ F_ SAT_ SUN_

Lab test required during camp.

CBC _____ Diff _____ Chem-7 _____ Chem 10 _____ LFTS _____ PT/PTT/INR _____

Other _____

Fax results to: _____ Attention: _____

Treatments required during camp.

_____

_____

_____

Other:

_____

_____

_____

_____

_____

X Physician's Signature _____

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