



**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: \_\_\_\_\_

\_\_\_\_\_

Has your patient been vaccinated for Covid? \_\_\_ Yes \_\_\_ No

If yes, when? \_\_\_\_\_

Does your patient have any behavioral problems? \_\_\_ Yes \_\_\_ No

AD(H)D  Oppositional  Eating Disorder Other \_\_\_\_\_

If yes, please explain \_\_\_\_\_

\_\_\_\_\_

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.

<u>Current Medication</u>	<u>Route</u>	<u>Exact Dosage</u> <u>patient receives</u>	<u>Frequency</u>	<u>Times</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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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