



Camper's First Name _____ Last _____

P. O. Box 8571
Spokane, WA 99203
509 474-6725
509 474-6706 Fax
www.beatsandrhythms.org

Current WT: _____ kg

Camper Medical Cardiology Form

Dear Parent/Legal Guardian:

Please sign and submit this form to your child's pediatric cardiologist to return directly to our camp office. No camper will be allowed to attend camp without his/her cardiology and medical forms approved by the nursing staff **Three Weeks** prior to your child's first day of camp. The camp office is not responsible for any outstanding forms.

I hereby authorize release of the information requested on this form to Beats & Rhythms, Inc. it's delegates and other medical care providers that they deem appropriate and necessary.

Camper's Name: _____ DOB: _____ Sex M/ F

Parent/Legal Guardian (print): _____

Signature of Parent/Legal Guardian: _____ Date _____

Pediatric Cardiologist Name: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip code: _____

Dear Physician:

Your patient is applying to attend summer camp. Your cooperation is requested in providing our medical staff with pertinent medical history about your patient. All information is confidential and solely for the guidance of the Beats & Rhythms medical staff. Please use information from the most recent visit (within the last 12 months) in completing this form and return it to our camp office as soon as possible, as our medical staff needs to review it before accepting this camper. Thank you for your assistance.

PLEASE print or type. Medical staff must be able to CLEARLY read all information. This is vital to our programming and staffing.

Recommended Subacute Bacterial Endocarditis Prophylaxis

- None
- Standard Amoxicillin Regimen
- Erythromycin
- Other: _____

Circle the letter below describing the level of exercise tolerance in which the applicant is able to participate.

A) FULL ACTIVE PARTICIPATION WITH NO RESTRICTIONS

Participates in non-competitive games

B) FULL ACTIVE PARTICIPATION WITH MODERATE EXERCISE

Participates in non-competitive games, which may involve running short distances

C) PARTIAL ACTIVE PARTICIPATION WITH LIGHT EXERCISE

Participates in limited activities, camper rests occasionally

D) LIMITED ACTIVE PARTICIPATION WITH NO EXERCISE

Must rest frequently and often, participate in sedentary activities only.

Allergies:

| Medication/Trigger | Date of the last Reaction | Type of Reaction |
|--------------------|---------------------------|------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medications:

| Medication / Strength / SIG: | Special Instructions: |
|------------------------------|-----------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Non-prescription medications we stock in the camp infirmary are listed below:

Please check those which we **SHOULD NOT** administer

| | | | | | |
|--------------------------|---------------|--------------------------|--------------------|--------------------------|------------------|
| <input type="checkbox"/> | Acetaminophen | <input type="checkbox"/> | Chloraseptic Spray | <input type="checkbox"/> | Meclazine |
| <input type="checkbox"/> | Advil | <input type="checkbox"/> | Cough Medicine | <input type="checkbox"/> | Milk of Magnesia |
| <input type="checkbox"/> | Benadryl | <input type="checkbox"/> | Dramamine | <input type="checkbox"/> | Pepto Bismol |
| <input type="checkbox"/> | Caladryl | <input type="checkbox"/> | Kaopectate | <input type="checkbox"/> | Sudafed |

Describe any recent operations, or serious illness. Do they require treatment? _____

Describe any physical disability or physical limitation effecting camp activity: _____

Describe any psychological problems that you are aware of that could impact camper's participation: _____

Describe any pertinent findings on examination that may require monitoring while at camp: _____

Cardiac Rhythm/Device History

Does applicant have a history of dysrhythmias? **YES NO** If Yes, Date of Last Episode: _____

Please describe: _____

Has there been any recent cardiac concerns/medical events? _____

Does applicant have a **PACEMAKER OR ICD** **YES NO** Date of Insertion: _____

Reason for Implantable Device: _____

Pacemaker

Brand: _____ Model: _____ Date of Last Interrogation: _____

Programmed to: _____ Mode: _____ Lower Rate: _____ Upper Rate: _____

ICD

Brand: _____ Model: _____ Date of Last Interrogation: _____

Has ICD discharged recently and how often: _____

PLEASE SEND COPIES OF LAST PROGRAMMED SETTING FROM ALL DEVICES

Cardiac Transplant Only

Date of Transplant: _____ Surgeon: _____

Name of Center: _____ Phone: _____

Evidence of Rejection: **YES NO** Last Cardiac Biopsy Date: _____

If evidence of rejection, type and grade: _____

Physical Exam: (Can be replaced by dictated report)

Height: _____ Weight: _____ Heart Rate: _____ O₂ Saturation: _____

Blood Pressures: RA: _____ LA: _____ RL: _____ LL: _____

Pulses: RUE: _____ LUE: _____ RLE: _____ LLE: _____

Cardiovascular: _____ Precordial Activity: _____ Murmurs: _____

Neurological: _____ Lungs: _____

Abdomen: _____ GI/GU: _____

I have examined _____ who is physically able to engage in camp activities, except for the level of exercise tolerance circled on first page.

Physician's Signature: _____ Date: _____

Physician's Name: _____ Office Phone: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip code: _____

We would like to thank you for helping us to make Camp a safe place for children who are living with heart disease. If any cardiac related event occurs while your patient is at camp, we will contact you as soon as possible.