

MEDICAL PROVIDER EVALUATION AND ASSESSMENT

Please note: For UNM patients, if your child has been seen **within a six month period prior** to Camp Enchantment, the UNM Pediatric Oncology staff can complete this portion of the application. However, if your child has not been seen by a provider within the last 6 months, please schedule an appointment for an exam with your oncologist or Primary Care Provider.

_____ **Seen by UNM Pediatric Oncology Provider**

HT (cm)		Labs:	Required if received chemo in last 3 months
WT (kg)		WBC	
B/P		H/H	
Pulse		PLTS	
RR		ANC	

Physical Exam:

System	Normal	Abnormal	Not Examined	System	Normal	Abnormal	Not Examined
HEENT				Extremities			
CV				Spine			
Pulmonary				Neurologic			
Abdomen				Skin			

Please explain any abnormal findings: _____

Cancer Diagnosis:	Date of Diagnosis:
Remission on Therapy	Remission off therapy since:
Relapse on Therapy	Relapse off therapy since:
Surgery: Type:	Date:
Radiation Therapy Dates:	Site:

Central Line: N/A Port Broviac PICC

Central line care: Flushes: _____ Dressing change _____ Cap change: _____

G-tube feedings/care: _____

Hardware or implants (VP shunt, Omayo etc): _____

Please submit treatment plan or roadmap if applicable. If camper is on a clinical study, please note if any study medication that will need to be administered at camp: _____

*** If a camper has had chemotherapy within the last month, his/her most recent lab work must be sent to the CENM prior to camp. Since low blood counts, abnormal lab results or new physical findings may jeopardize a camper's safety, it is possible that an approved camper's application may be overturned prior to camp.**

I have examined _____ and reviewed this child's application in its entirety.

It is my opinion that this child:

_____ may attend Camp Enchantment/Camp Super Stars

_____ may NOT attend Camp Enchantment/Camp Super Stars

PROVIDER SIGNATURE: _____ LICENSE: _____

PRINT PROVIDER NAME: _____ DATE: _____

ADDRESS: _____ PHONE: _____

EMAIL: _____