Nevada Chapter
NATIONAL BLEEDING DISORDERS FOUNDATION

PHYSICIAN'S FORM

(COMPLETED BY HEMATOLOGIST OR PRIMARY CARE PHYSICIAN)

Please note: physician signature is required

Camper Name: _____ **Date of Birth:** _____ /_____ /_____

Date of last exam: _____ /_____ /_____ **Weight:** _____ lb. **Height:** _____ ft. □ **Male** □ **Female**

Bleeding Disorder: □ Yes □ No **Clotting Disorder:** □ Yes □ No **Carrier:** □ Yes □ No

Sibling: □ Yes □ No **Other:** _____

DIAGNOSIS

Factor Deficiency	□ Factor 8 □ Factor 9 □ vWD1 □ vWD2 □ vWD2a □ vWD2b □ vWD2c □ Carrier 8 □ Carrier 9 □ Other:
Severity	□ Mild □ Moderate □ Severe
Factor Activity Level	_____ %
Inhibitor	□ Yes □ No □ Date of last inhibitor test _____ /_____ /_____

TREATMENT

Factor Medication: _____ Routine Dose: _____ Units or _____ U/kg

Does camper/staff self-infuse? □ Yes (independently) □ Yes (needs help) □ No (but would like to learn)

Does camper/staff use EMLA prior to infusing? □ Yes □ No

DDAVP/Stimate used? □ Yes □ No Amicar used? □ Yes □ No

Target joints: □ Yes □ No □ If yes, state which joints: _____

Does camper/staff have a Portocath or Brovic/Hickman? □ Yes □ No Can they go swimming? □ Yes □ No

ALLERGIES

Drug allergy: _____ Type of Reaction: _____ Treatment: _____
Drug allergy: _____ Type of Reaction: _____ Treatment: _____
Drug allergy: _____ Type of Reaction: _____ Treatment: _____

Food allergy: _____ Type of Reaction: _____ Treatment: _____
Food allergy: _____ Type of Reaction: _____ Treatment: _____
Food allergy: _____ Type of Reaction: _____ Treatment: _____
Food allergy: _____ Type of Reaction: _____ Treatment: _____

Additional food allergies: _____

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PHYSICIAN'S FORM Continued

Camper's Name: _____

PYSCHOSOCIAL

Is the camper's/staff member's development appropriate for his/her age? □ Yes □ No
□ if no, please explain:

OTHER

Recent surgery or illness: □ Yes □ No
□ if yes, please explain: _____

Recent contact with a contagious disease: □ Yes □ No
□ if yes, please explain: _____

Any special instructions? □ Yes □ No
□ if yes, please explain: _____

MEDICATIONS

Is camper/staff on prophylaxis? □ Yes □ No
If yes, please indicate dosage schedule for camp week in chart below.

Medication	Dose	Mon	Tue	Wed	Thur	Fri	
							□ as needed
							□ as needed
							□ as needed
							□ as needed
							□ as needed
							□ as needed
							□ as needed

PHYSICIAN CONTACT INFORMATION

Physician name: _____ Office/Clinic Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ After hours/Emergency Phone: _____

My signature below indicates I/my staff has completed the above Physician's Form for the NV Chapter teen camping program.

Physician's Signature (mandatory): _____ Date: _____