

# Camp Carefree April 23-25, 2010

Date: \_\_\_\_\_

Patient Information

Patient Name: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone/Cell #s: \_\_\_\_\_

E-mail: \_\_\_\_\_

Current Address (if not same as above): \_\_\_\_\_

T-shirt size: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

PATIENT SIGNATURE: \_\_\_\_\_

## Patient/Medical Health Form

To Be Completed By Patient's Physician

**Brief Medical Summary** (i.e., diagnosis, treatment course, relapses, recurrences, surgeries or radiation, physical disabilities and/or limitations, cognitive status and/or changes, behavior problems)

\_\_\_\_\_  
\_\_\_\_\_

**Comorbidities** (i.e., high blood pressure, heart disease, diabetes, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**Describe, if applicable, convulsions/seizures**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies** (including medicine and food allergies)

\_\_\_\_\_  
\_\_\_\_\_

**IV Access** \_\_\_\_\_ **Defective Vision** \_\_\_\_\_

**Defective Hearing** \_\_\_\_\_ **Muscular Problems** \_\_\_\_\_

**Restrictions** \_\_\_\_\_

**Name and date of last chemotherapy to be given prior to retreat** (April 23, 2010)

\_\_\_\_\_  
\_\_\_\_\_

**Physician's Statement:** I have examined \_\_\_\_\_, who is physically able to engage in camp activities, except for the physical limitations and restrictions listed above. I hereby verify the information concerning health matters, drugs and immunizations, and all medications to be given.

\_\_\_\_\_, M.D. Date: \_\_\_\_\_

Send completed registration to: Anderson Network  
ATTN: Marisa Mir  
FAX: 713-745-5231  
andersonnetwork@mdanderson.org  
Telephone: 713-792-2553

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