HOSDC
HEMOPHILIA ASSOCIATION OF SAN DIEGO COUNTY

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: ________________________

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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 HASDC'S 2023 camping program.

Physician's Signature (mandatory): ______________________________ Date: _______________