

# Camp HemoVon Medical Information

## To Be Completed by Physician

Camper Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date of last exam: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

24 Hour Telephone Number: \_\_\_\_\_

## Camper's Medical History

### Diagnosis

- Factor VIII Deficiency
  - Mild  Moderate  Severe
- Factor IX Deficiency
  - Mild  Moderate  Severe
- vonWillenbrand's Disease
  - Type I  Type II  Type III
- Other, please explain \_\_\_\_\_

Factor Level \_\_\_\_\_

### Inhibitor

- Yes, when? \_\_\_\_\_, on immune tolerance? \_\_\_\_\_
- No

### Treatment

- Home Infusion
- Self Infusion

If not, who infuses? \_\_\_\_\_

Treatment Product \_\_\_\_\_

(brand of factor, DDAVP, etc.)

### Dosage (number of units)

Minor bleed \_\_\_\_\_

Major bleed \_\_\_\_\_

**Approximate number of bleeds per month** \_\_\_\_\_

**Is camper on prophylactic schedule for factor infusions?**

Yes  No

If yes, what is the dose and schedule? \_\_\_\_\_

**Major sites of bleeds in past year (Target Joints):** \_\_\_\_\_

**Any reactions to transfusions?**

Yes  No

If yes, type of reaction \_\_\_\_\_

<b>Physical Exam:</b>	<b>Normal</b>	<b>Abnormal</b>	<b>Explain</b>
HEENT:	_____	_____	_____
Chest:	_____	_____	_____
Heart:	_____	_____	_____
Abdomen:	_____	_____	_____
Skin:	_____	_____	_____
Neurologic:	_____	_____	_____
Orthopedic:	_____	_____	_____
Psychological:	_____	_____	_____

**Other Medical Issues**

Hepatitis B antibody

positive  negative  unknown

Hepatitis C antibody

positive  negative  unknown

HIV antibody

positive  negative  unknown

Allergies (Drugs, food, hayfever, pets, etc.)

Yes  No

Other

\_\_\_\_\_

**Restrictions** (Physical or otherwise which may interfere with camp Activities)

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Anything else we should know or suggestions regarding this child?

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Assessment and recommendation of camper

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Physician's signature

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Date