

**Cardiologist** First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_.

**Patient Information**

\* Name (First and Last)

\* Gender/Sex

\* DOB

Month	Day	Year
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\* Age

\* Cardiologist

\* Date of Last Cardiologist Visit

Month	Day	Year
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**Cardiac Diagnosis**

\* Cardiac Diagnosis

\* Procedures Performed?

Yes

No

\* Details

\* Add another diagnosis entry?

Yes

No

\* Cardiac Diagnosis

\* Procedures Performed?

Yes

No

\* Add another diagnosis entry?

Yes

No

## Physical Exam

\* Units

English (ft/lbs)

\* Feet

Feet

\* Inches

Inches

\* Weight (lbs)

Weight (lbs)

\* H.R

\* B.P.

\* SaO2 saturation range

\* Neurological Normal

Yes

No

\* Lungs Normal

Yes

No

\* Cardiovascular

\* Pulses Normal

Yes

No

\* GI Normal

Yes

No

Please add any additional information/details about the above questions here:

## Prescribed Medications:

### Allergies

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\* Does your patient have any allergies?

Yes

No

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\* Does your patient carry an EpiPen?

Yes

No

### Medication

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\* Please list your patient's medications below.

### High Risk Medications

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\* Is your patient taking anticoagulation medication?

Yes

No

Please list all other medications below:

### Cardiac Rhythm/Device History

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\* Does applicant have a history of dysrhythmia?

Yes No

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\* Does applicant have a PACEMAKER or ICD?

Yes No

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### Cardiac Transplant Only

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\* Has this participant had a transplant?

Yes No

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### Pulmonary Hypertension

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\* Is there a diagnosis of pulmonary hypertension for your patient?

Yes No

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\* Is your patient on IV medication for pulmonary hypertension?

Yes No

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\* Is your patient on IV medication for pulmonary hypertension?

Yes No

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Please add any additional information/details about the above questions here:

## Non-Cardiac Diagnoses & Behavioral Information

\* Describe non-cardiac diagnoses and any treatment or surgery you are aware of

\* Describe any behavioral concerns you think could impact this patient's participation

\* Has there been any recent cardiac concern / medical event?

Yes No

\* Is there anything else we should know?

Yes No

## Activity Participation

\* Does applicant participate in a physical education program at school?

Yes No

\* Please select one of the letters below describing the level of activity at which the applicant is able to participate .

Please select one of the letters below describing the level of activity at which the applicant is ab

A) FULL ACTIVE PARTICIPATION WITH MODERATE EXERCISE - Participates in non-competitive games which may involve running short distances

B) PARTIAL ACTIVE PARTICIPATION WITH LIGHT EXERCISE - Participates in limited activities. Camper rests occasionally

C) LIMITED ACTIVE PARTICIPATION WITH NO EXERCISE - Must rest frequently and often. May participate in sedentary activities only.

Is there anything else we should know?

Yes No

## Doctors Statement

I have examined this child, who is physically able to engage in camp activities, except for the limitations and restrictions listed above.

\* Your Name

DECLINE AUTHORIZATION

ACCEPT AUTHORIZATION

\* Some of my other patients may benefit from attending Camp del Corazon. Please send me a few brochures.

Yes

No

\* Pediatric Cardiologist Address

\* City

\* Zip Code

\* State

State



\* Office Fax

\* Office Phone Number

\* Emergency/after-hours contact