



Canadian
Cancer
Society

CAMP GOODTIMES

BRITISH COLUMBIA AND YUKON

THIS IS PART 2 OF THE CAMP GOODTIMES APPLICATION FOR KIDS, TEENS, and LITs with a HISTORY OF CANCER

Please have the following forms completed by your child's clinician and returned to our office before coming to camp.

***Clinician is either: The Primary Nurse or Physician overseeing your child's medical care. If the Primary Nurse is filling out these forms, please have a Physician co-sign as well.**

- **Form 1 – CURRENT TREATMENT FORM**
 - To be filled out by a Clinician (preferably within two weeks of coming to camp)
 - This is **ONLY** for campers that are on active treatment for cancer

- **Form 2 – CLINICIAN'S EVALUATION FORM**
 - To be filled out for campers that are currently on **ACTIVE** treatment or have been treated for cancer **within the last 5 years**

FORM 1: 2012 CURRENT TREATMENT FORM

IF THE PARTICIPANT IS CURRENTLY RECEIVING CANCER TREATMENT, Please have their Clinician (Physician/Primary Nurse) complete this form. (Note to Clinician: Camp Goodtimes take place annually in July & August)

NOTE to parent/guardian:
 If your child is **currently receiving chemotherapy, radiotherapy or other treatment**, a **blood count is required one week to ten days prior to camp**. This form must be received at least two (2) days before the participant arrives at camp so that it can be reviewed by the Clinical Coordinator. If any concerns arise from the results, you will be contacted. Any other current blood count results can be brought to the Camp Nurse on Registration day.

This form can be faxed or mailed to our office: Attention: Kate Kelsey, Clinical Coordinator
Phone: 604.675.7142 or 1.800.663.2524 ext. 7142
Fax to: 604.675.7124
Mail to: Camp Goodtimes, CCS / 565 West 10th Avenue / Vancouver, BC / V5Z 4J4

Participants' Name _____
 Date of Birth: _____ / _____ / _____
Year Month Day

List the most recent forms of treatment and dates (chemotherapy/radiation):

Date	Chemotherapy (Type, amount)	Radiation (location on body)

DATE OF BLOOD WORK _____ (within 7-10 days of the first day of camp)

HEMOGLOBIN _____ 9/L

WHITE CELL COUNT _____ X 10⁹/L

ABSOLUTE NEUTROPHIL COUNT _____ x10⁹/L

PLATELET COUNT _____ X 10⁹/L

What sort of trend have the participants' blood counts shown (increasing, decreasing)?

Clinician's Name and Designation (Physician/Primary Nurse) (Please Print): _____

NOTE: If the Primary Nurse is filling out this form, please have it double signed by a Physician.

Office Phone: _____
 Emergency Phone Number/Pager: _____
 Date: _____ / _____ / _____ (year/month/date)
 Primary Nurse's Signature: _____
 Physician's Signature: _____

FORM 2 (PART 1 OF 2): 2012 *Clinician’s EVALUATION*

This Clinician’s Evaluation Form is **necessary** only if:

1. Your child is on **active treatment for cancer** OR
2. Your child has received treatment for cancer **within the last five years**

If the participant is on active treatment, have this form completed within 2 weeks of the start of his/her camp session. Please remember the Current treatment form as well.

Participants Name: _____ Date of Birth: ____/____/____ (year/month/date)

Clinician’s Examination: DATE: ____/____/____ (year/month/date)

Diagnosis	Being Closely Monitored by a Medical Practitioner	Stable (re-evaluation only when necessary)

Any known allergies (please specify reaction and treatment):

Is this participant on any medication (chemotherapy / ventolin / vitamins etc...)? yes no

*****If the answer is yes, please fill out the medication information on the next page*****

Patient Findings:

Is there anything else we should know about this participant? (Behavioral, history of being (+) for MRSA, social concerns, PHYSICAL LIMITATIONS.)

CCS Camps program may include some or all of the following optional activities, depending on the nature of the session: swimming; canoeing; kayaking; high and low ropes course; climbing wall; archery; rappelling; hiking; field sports; arts and crafts projects; theatre. Additional activities include: daily rest time; meal time; minimum scheduled 8 hours of sleep time; peer support sessions; and minor activities within the physical scope of items already outlined.

Clinician’s Name and Designation (Please Print): _____

Office Phone: _____ Emergency Phone Number/Pager: _____

Primary Nurse’s Signature: _____

Physician’s Signature: _____

Contact Information

Clinical Coordinator: Kate Kelsey, RN, BEd

Phone: 604.675.7142 or 1.800.663.2524 ext. 7142 **Fax:** 604.675.7124

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