Information and release form MEDICAL PART
CAMP PARTICIPANTS (TRANSPLANT RECIPIENTS)
MEDICAL INFORMATION

Please carefully complete this form.

CHILD INFORMATION

First name	**Family name**	**M** ☐ **F** ☐

Date of birth (DD/MM/YY) Age Nationality

Passport number Expiry date (DD/MM/YY)

TRANSPLANT INFORMATION
Please ensure that all the following appropriate questions are answered:

Type of transplant

Date of transplant Date of results

Transplant unit name Medical adviser's name*

Address

Post code City Country

Telephone Fax E-mail

Local hospital name (if different to transplant unit)

Emergency (24/7) local hospital telephone (e.g. on-call physician)

***Please ensure that the above named medical adviser completes the comments section (page 3). All transplants:**

Hb >10gm/dl, BP < 97th centile, creatinine <200 µmols/l ** estimated Glomerular Filtration Rate*

Hb Creatinine or eGFR* Albumin WCC

Platelets Blood pressure Diabetes - Yes ☐ No ☐

Musculo-skeletal disorder - Yes ☐ No ☐ Vision - Normal ☐ Impaired ☐ Blind ☐

Please indicate any positivity to Hep B ☐ Hep C ☐ HIV ☐ (important in the event of emergency hospital admission)

Liver transplants:

Liver function tests (most recent level)

Bilirubin AlkPhos ALT AST

INR/Prothrombin time

Heart and lung transplants:

Good graft function as demonstrated by cardio-angiography, echocardiography, stress ECG or lung function studies.

Cardio-angiography

Echocardiography Exercise

ECG

Lung function tests

Haemopoetic cell (bone marrow) transplants:

WBC >3x10^9/l, neutrophils >1.5x10^9/l, platelets >80x10^9/l

WBC Neutrophils Platelets

MEDICATION INFORMATION - Please give comprehensive information (use a separate sheet, if necessary)

Medication	Trough level at last check-up	Morning (AM)		Afternoon (PM)		Evening	
		Time	Dose	Time	Dose	Time	Dose
Prograf *Based on 12 hour trough*							
Ciclosporin *12 hour or C2 monitoring*							
Mmycophenolate *Based on 12 hour trough*							
Rapamycin *Daily trough*							

HEALTH INFORMATION

Please ensure that all the following questions are answered:

Child's height (cm) Child's weight (kg)

Microbiology/infection

Is your child prone to recurrent infections requiring antibiotics? Yes ☐ No ☐

If yes, indicate anatomical site (e.g. throat, chest, urinary tract)

If yes, usual organism and sensitivities (if known)

If yes and it is appropriate to treat empirically whilst at camp, please provide one course of treatment with your child's medications and indicate the name and dose below, together with other, appropriate, antibiotics:

Antibiotic name	**Dose**
☐ Provided:	
Alternative:	
Alternative:	

Analgesics

Analgesic	**Permitted / non-permitted**	**Dose**
NSAID	☐ Permitted ☐ Non-permitted	
Opioid	☐ Permitted ☐ Non-permitted	
Paracetamol	☐ Permitted ☐ Non-permitted	

Is your child immunised against or has your child ever contracted the following?

Polio Yes ☐ No ☐ Mumps Yes ☐ No ☐ Measles Yes ☐ No ☐
Tuberculosis Yes ☐ No ☐ German measles Yes ☐ No ☐ Diphtheria Yes ☐ No ☐
Whooping cough Yes ☐ No ☐ Tetanus Yes ☐ No ☐ Chicken pox Yes ☐ No ☐

Date of last tetanus injection

Does he/she have a history of any of the following?

Diabetes Yes ☐ No ☐ Asthma Yes ☐ No ☐ Stomach upsets Yes ☐ No ☐
Seizures/Fits Yes ☐ No ☐ Sleep problems Yes ☐ No ☐
Bedwetting Yes ☐ No ☐ Ear problems Yes ☐ No ☐

Other

Has he/she ever had an allergic reaction to any of the following?

Penicillin Yes ☐ No ☐ Certain foods Yes ☐ No ☐

Other and/or details

_____

Bee/wasp sting Yes ☐ No ☐ Other medication Yes ☐ No ☐

Does he/she have any special dietary requirements or eating disorders?

Yes ☐ No ☐ Details _____

_____

Are there any other medical, social or emotional considerations we should know about?

Yes ☐ No ☐ Details _____

MEDICAL ADVISERS'S COMMENTS

Please comment on graft function, fitness and suitability to engage in the camp's activities (please use CAPITALS).

_____

_____

_____

Signed _____ Date _____

PARENT'TS / GUARDIAN'S DECLARATION

The child named above has my permission to engage in all the camp's activities, unless otherwise noted and indicated in the medical advisers's comments above. I hereby give permission to the camp's organisers to authorise, on my behalf, any emergency medical care (including surgery) which, on the recommendation of qualified medical personnel, may be deemed necessary. In such circumstances, I understand that the camp's organisers will seek to advise me or the emergency contact person at the earliest possible opportunity.

Signed _____ Date _____