

Camper Name: _____

Birthdate: _____



KIDNEY DISEASE FORM

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

This form, in addition to the Physical Exam form, must be completed by the medical

Specialty MD: _____ Day Phone: _____ After Hours Phone: _____

Address: _____ Email: _____

Hospital: _____ Nurse Coordinator: _____

Diagnosis: _____ Date of Diagnosis: _____

Secondary Diagnoses: _____

Current Treatment: _____

Categories/Complications:

Kidney Transplant? YES NO If YES, Date of transplant: _____ # of transplants: _____

Kidney Wasting Syndrome? YES NO If YES, Water Only Electrolytes and water

Chronic Kidney Disease? YES NO If YES, what stage CKD: Stage 1-2 Stage 3 Stage 4 Stage 5 (ESRD)

Please provide BP parameters: **Call for BP greater than** _____ **OR Less than** _____

Most recent creatinine: _____ Most recent GFR _____

Nephrotic Syndrome? YES NO If YES, is it in remission? YES NO History of Relapses? YES NO

If YES, # of relapses: _____ Currently in relapse? YES NO Date of relapse: _____

Hypertension? YES NO If YES, baseline BP: _____

Anemia? YES NO If YES, most recent Hgb _____ Hct _____

Diabetes? YES NO If YES, what is the cause? _____

If YES, what type of diabetes? Type 1 Type 2 **(If insulin is required, please attach most recent insulin regimen)**

For Type 2 Diabetes- please indicate diet recommendations for this camper: No Added Sugar (limit juice to 4oz, no Gatorade)

Low Sugar (no juice, no Gatorade, special snack) Sugar Free (Crystal Lite, sugar free snacks) Carb counts required

History of Infection with: MRSA VRE C Diff If YES, has this infection been cleared? YES NO

If NO, is child colonized but asymptomatic? YES NO If NO, details: _____

Devices:

Dialysis? YES NO If YES, indicate type: Hemodialysis (Family camp ONLY) Date started: _____

Peritoneal Dialysis Date started: _____ **(Please attach Master Dialysis Form)**

Does the child receive tube feedings or require a central line? YES NO If YES, please complete the Infusion Pump form

Does the child regularly receive lab work? YES NO If YES, please provide a recent copy

Labs while at camp? YES NO If YES, please list lab(s) and date needed: _____

Please attach most recent clinic note

Physician Name (Print): _____ Signature: _____ Date: _____

Completed By (Print): _____ Signature: _____ Date: _____

Upload on the Parent Dashboard, Fax completed form to 888-524-2477 or email to camperrecruiter@roundupriverranch.org

Standard Precautions/Adaptations for Kidney Disease and Kidney Transplant

- 1) All campers have their weight and BP checked upon arrival to RRR.
- 2) Blood Pressures are checked and recorded for all campers each morning and as needed.
- 3) Weights are checked daily for all campers who are on Peritoneal Dialysis, and as needed.
- 4) Campers are encouraged to drink 2-3 liters of fluids/day unless they have a fluid restriction. Fluid recommendations are adjusted slightly at camp to prevent dehydration from outdoor activities in the heat of summer. The adjustment is based on campers' activity levels each day and the outdoor temperature.
- 5) We provide a healthy diet that is low in cholesterol and refined sugars, and includes freshly prepared food at every meal. During our kidney session we provide a basic Renal Diet this is low in sodium (<1500 mg/day) and avoids foods high in potassium and phosphorous.

For campers with specific dietary requirements not served by the basic renal Diet, we work with our dietary team to ensure that each camper's dietary needs are met.

Dietary restrictions/requirements outside of basic Renal Diet outlined above? YES NO (If YES, provide details below)

- Sodium restriction: less than ____mg/day Higher Sodium diet: greater than ____mg/day
- Potassium restriction Higher potassium diet Phosphorous Restriction

Fluid restrictions/requirements outside the 2-3 Liters/day outlined above? YES NO (If YES, provide details below)

- Fluid Restriction: Maximum fluid intake of ____Liters/day OR ____ounces/day
- Push fluids: Minimum Fluid intake of ____Liters/day OR ____ounces/day

Camp Program/Activity Area Adaptations: (Please check all that apply)

- No Contact Sports
- Padding to be applied at the climbing wall/zip line for :
 - Kidney Transplant Location of kidney:_____
 - Ostomy Type:_____ Location:_____
 - Catheter Type:_____ Location:_____
 - Stoma Type:_____ Location:_____
 - Port Type:_____ Location:_____
 - Other Type:_____ Location:_____

Water Related Activity Restrictions (We do NOT have a swimming pool) :

- Peritoneal Dialysis catheter Date of surgery:_____
- Immunosuppression Precautions
- No boating
- Shower only / no bathing
- No activities that involve spraying or squirting of water
- Participation in activities involving water with accommodations:
 - Cover port with occlusive dressing
 - Cover catheter with occlusive dressing
 - Other Please describe;_____

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