

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: \_\_\_\_\_

**Standard Precautions/Adaptations for Kidney Disease and Kidney Transplant**

- 1) All campers have their weight and BP checked upon arrival to Roundup River Ranch.
- 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:

- |  |                           |                 |
|--|---------------------------|-----------------|
| <input type="checkbox"/> Kidney Transplant | Location of kidney: _____ |                 |
| <input type="checkbox"/> Ostomy            | Type: _____               | Location: _____ |
| <input type="checkbox"/> Catheter          | Type: _____               | Location: _____ |
| <input type="checkbox"/> Stoma             | Type: _____               | Location: _____ |
| <input type="checkbox"/> Port              | Type: _____               | Location: _____ |
| <input type="checkbox"/> 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: \_\_\_\_\_