Camper Name:______________________________ Birthdate: ______________

BONE MARROW/STEM CELL TRANSPLANT FORM

TO BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER

This form, in addition to a recent clinic note, must be completed bythe medical specialist for all applicants interested inparticipating in a transplantsession.

Transplant Specialist______________ Day Phone______________ After Hours Phone ______________

Address______________________________ Email ______________________________

Hospital (where child is treated):______________________ Nurse/Coordinator:______________________

Type of transplant(s): ☐ Autologous (Auto) transplant ☐ Allogeneic (Allo) transplant

Source of stem cells: ☐ Bone Marrow ☐ Peripheral blood ☐ Umbilical cord blood

Date of transplant: __________ Location of transplant (unless same as above) ______________________

Underlying diagnosis requiring transplant: ______________________________

Adrenal suppression? ☐ No ☐ Yes If yes, what is the stress dose for steroids? ______________________

On immunosuppressive therapy? ☐ No ☐ Yes If yes, describe______________________________

Have immunizations been restarted? ☐ No ☐ Yes *(If yes, please upload a copy of these new vaccines to this camper's application)*

History of Graft-vs-Host disease (GVHD)? ☐ No ☐ Yes If yes, date GVHD developed: __________

Treated with: ______________________________

Current state of GVHD: ☐ Active ☐ Not Active If active, describe treatment: ______________________

What organs are affected by GVHD? ______________________________

Severity of involvement:______________________________

Transfusions: ☐ Packed red blood cells ☐ Platelets Last transfusion date:________ Frequency of transfusions: __________

Prior transfusion reactions? ☐ No ☐ Yes Special transfusion considerations/ needs? ______________________

Other medical or surgical complications since transplant? ☐ PTLD ☐ CMV Disease ☐ At risk for bleeding ☐ Other (May attach clinic notes):________

____

Camp altitude is 6300 feet. Are there cardiac or pulmonary issues to consider? *(If yes, please complete the cardiac and/ or lung disease forms)*:

____

Central Line? ☐ No ☐ Yes *(If yes, please complete the central line form)*

Anticoagulants: ☐ No ☐ Yes If yes, type: ☐ ASA ☐ Coumadin ☐ Other ______________________

Diabetes: ☐ No ☐ Yes If yes: **Insulin dependent?** ☐ No ☐ Yes Endocrinologist: ______________________

Does this child require labs while at camp? ☐ No ☐ *Yes* *If yes, please list labs and date needed*:______________________

Please attach last transplant clinic note with current med list

______________________	______________________	__________
Physician Name (Print)	**Signature**	**Date**
______________________	______________________	__________
Completed by (Print Name)	**Signature**	**Date**

Upload to parent dashboard or fax form to 888-524-2477