

Medical Sign-Off Form 2024
(Patients On-Treatment Only)

RETURN THIS FORM

Must be completed and signed by a physician or nurse practitioner who has examined your child within the last 12 months.

Please complete and return to:
Fax to The Goodtimes Project
at 206.877.4437, or email a PDF to
camp@thegoodtimesproject.org.

Questions: 206.255.3800

Parent to complete this box.

Camp session applying for:

- June Session= June 23–29, 2024
- July Session= July 14–20, 2024
- Mini Camp= July 17, 2024

PLEASE PRINT OR TYPE

I have examined: _____
(Patient's name)

In my opinion, the above named person's condition does not preclude his/her/their attendance at camp.

Diagnosis and Disease Site: _____

Current Treatment Status (circle one): ON OFF

If **on** treatment:

Initial Diagnosis Date: _____

Dates of Recurrence: _____

Current Chemotherapy: _____

Line Yes No If yes, type: _____

VP Shunt or Ommaya Yes No _____

Feeding Tube Yes No _____

Other/Complications Yes No _____

If S/P BMT:

Date of BMT: _____

Date of 2nd BMT: _____

Line Yes No If yes, type: _____

Feeding Tube Yes No _____

GVHD Yes No _____

The Goodtimes Project
7400 Sand Point Way NE, #101S
Seattle, WA 98115
Email: tanya@thegoodtimesproject.org
Phone: 206.255.3800 • Fax:
206.877.4437



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PATIENT'S NAME: _____

ALLERGIES: Please list drug, food, or environmental allergies and describe

Allergy	Reaction/Treatment Required

Varicella Immune: Yes No Status Unknown

Camper on Chemotherapy at camp or within 72 hours of start of camp? Yes No
(June session dates= June 23-29, 2024 • July session dates = July 14-20, 2024 • Mini Camp date= July 17, 2024)

Additional Health Information Needs:

Nurse Practitioner/Physician's Name (please print): _____

Nurse Practitioner/Physician's Signature: _____

Date: _____

Address: _____

Phone: (_____) _____ Fax: (_____) _____

