



The location of attendance for each camper is made at the discretion of Camp Liberté administrators. This decision is based on the needs and wellbeing of the camper and the most cost effective alternative.

**PHYSICIAN REFERRAL FORM**

- Dates TBD - Saint-Alphonse-Rodriguez, QC (Ages 7 - 12)**       **Dates TBD - Ennismore, ON (Ages 7-14)**  
 **Dates TBD - Bragg Creek, AB (Ages 7 - 14)**               **Dates TBD - Virtual Camp (Ages 7-14)**

For children with cutaneous disorders living in Canada

**To be completed by the Dermatologist:** (Please print all information)

Physician's name: \_\_\_\_\_

Office address: \_\_\_\_\_ Office phone: \_\_\_\_\_

City: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Province: \_\_\_\_\_ Postal code: \_\_\_\_\_ Email: \_\_\_\_\_

**I would like to recommend the following child:**

Child's name: First: \_\_\_\_\_ Last: \_\_\_\_\_

Gender:  Male  Female      Date of birth (DD/MM/YYYY): \_\_\_\_\_ Age: \_\_\_\_\_

Parent(s) names: \_\_\_\_\_  Father  Mother

Home address: \_\_\_\_\_ Home phone: \_\_\_\_\_

City: \_\_\_\_\_ Business phone: \_\_\_\_\_

Province: \_\_\_\_\_ Postal code: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_

Guardian name: \_\_\_\_\_ (if applicable)

Address: \_\_\_\_\_ Home phone: \_\_\_\_\_

City: \_\_\_\_\_ Business phone: \_\_\_\_\_

Province: \_\_\_\_\_ Postal code: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred language:  English  French

**Parent(s) / Legal guardian permission to propose the child as a potential camper:**      Date: \_\_\_\_\_

Name (please print): \_\_\_\_\_ Signature: \_\_\_\_\_

**Family Physician or Pediatrician**

Name: \_\_\_\_\_ Office phone: \_\_\_\_\_

City: \_\_\_\_\_ Cell phone: \_\_\_\_\_



**Brief description of child's skin condition:**

1. Condition: \_\_\_\_\_

2. Extent of condition:  Generalized  Limited

If limited, what areas are affected? \_\_\_\_\_

3. (a) Severity of condition:  Minimal  Moderate  Severe

(b) What is the treatment for this condition?

Skincare/hygiene:  Yes  No Special dressings:  Yes  No

Topical treatments? \_\_\_\_\_

Oral medication? \_\_\_\_\_

(c) If severe, please give full details of daily treatments:

\_\_\_\_\_  
 \_\_\_\_\_

4. (a) Additional medical considerations (e.g. asthma, severe allergies, attention deficit disorder, requires wheelchair, etc).

\_\_\_\_\_

(b) Other treatment:  Yes (Specify)  No

\_\_\_\_\_

5. Does child travel with a wheelchair?  Yes  No Is the wheelchair collapsible?  Yes  No

6. Behavioural problems:  Yes  No

If yes, level of severity:  Mild  Moderate  Severe

Briefly describe condition on back of form, or separate sheet

7. Level of care required: In order to accurately assess the amount of medical staff required, please identify below the level of daily care

required by this child.  Able to perform daily skin care regimen without assistance

Requires some assistance to perform daily skin care regimen Time required: \_\_\_\_\_

Requires extensive assistance to perform daily skin care regimen Time required: \_\_\_\_\_

Additional comments

\_\_\_\_\_  
 \_\_\_\_\_

Signature of Dermatologist: \_\_\_\_\_ Date: \_\_\_\_\_

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**Fax: 866-267-2178**  
**Email: info@campliberte.ca**

Campers who must be Canadian residents and should be at and least 7 years old on July 31, 2021 will be selected based solely on their medical condition without bias as to any other factors.

All patient information provided will be treated confidentially, as in any medical practice.