

Asthma Camp Physician Health Form

ASTHMA CAMP MEDICAL HISTORY AND PHYSICAL EXAMINATION - to be completed by physician

Date Rec'd _____

An important note to Healthcare Providers:

This Medical History and Physical Examination form is a mandatory part of your patient's asthma camp application. If applicable, please try to simplify the medication regime that the child follows during camp. For example: if a medication can be given TID, with meals, instead of QID (or BID instead of TID), this would be helpful for the child and the medical personnel. Furthermore, inhalation therapy with a nebulizer can be time consuming for the child at camp; please carefully review the child's need for this form of therapy.

Also, allergy shots will not be given at camp.

Child's name _____ Height _____ Weight _____ B/P _____

Date of last physical exam _____ / _____ / _____

Immunization Dates:

DT _____ Hepatitis B _____

MMR _____ Chicken Pox _____

HISTORY

Please circle Yes (Y) or No (N)

1. Is this patient under regular care?..... **Y / N** Date of last appointment _____ / _____ / _____

2. Have there been any hospitalizations for asthma in the PAST 5 YEARS?..... **Y / N** How many? _____
 Date of most recent hospitalization (month, year) _____ / _____

3. Has this child been:

a. In the ICU or intubated because of asthma in the PAST 5 YEARS? **Y / N** How many times? _____
 Date of most recent ICU admittance or intubation? _____ / _____ / _____

b. On oral corticosteroids within the PAST YEAR?..... **Y / N** How many times? _____
 Date of most recent course? _____ / _____ / _____

c. Hospitalized for reasons other than asthma?..... **Y / N** How many times? _____

4. Has this child received the following tests or evaluations in the past year?

Health/Development History..... **Y / N**

Physical Examination..... **Y / N**

5. Does this child have any of the following problems?

Convulsive disorders..... Y / N	Heart Disease..... Y / N	Discipline Problems..... Y / N
Hyperactivity..... Y / N	Fainting..... Y / N	Sleepwalking..... Y / N
Diabetes..... Y / N	Bedwetting..... Y / N	Constipation..... Y / N
Learning Disabilities..... Y / N	ADD..... Y / N	ODD..... Y / N
OCD..... Y / N	Other..... Y / N	Depression..... Y / N

Explain any "yes" answers _____

6. Does the Camp Healthcare team need to be aware of any of the following:

a. Known medical problems, besides asthma?..... **Y / N**

b. Known behavioral or psychological issues?..... **Y / N**

c. Foods that must be completely eliminated from this patient's camp diet?..... **Y / N**

d. Other allergy or sensitivity problems?..... **Y / N**

e. Specific medication issues?..... **Y / N**

f. Treatments you prefer **not** be used at camp?..... **Y / N**

g. Restrictions/limitations on participation in any asthma camp activities?..... **Y / N**

Please explain any "yes" answers (please be specific) _____

7. Based on the NHLBI's guidelines severity classification, how would you classify this child's asthma?

Intermittent Asthma Persistent Asthma: Mild Moderate Severe

8. How would you rate the severity of this child's asthma on a scale of 0 – 10? (Circle one number only)

(NO ASTHMA) 0 1 2 3 4 5 6 7 8 9 10 (SEVERE ASTHMA)

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MEDICATIONS

Please include asthma and non-asthma medications

DRUG NAME (include if it is an inhaler, nebulizer or pill)	STRENGTH	DOSAGE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGY INFORMATION

Is this child allergic to any:

MEDICATION? ___ Yes ___ No

Medication	Reaction (be specific)	Age of Last Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FOODS? ___ Yes ___ No

Food	Reaction (be specific)	Age of Last Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANIMALS or INSECTS? ___ Yes ___ No

Animal or Insect	Reaction (be specific)	Age of Last Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTHCARE PROVIDER'S AUTHORIZATION

I have examined the above camp applicant. My signature below indicates that I believe this patient is able to participate in an active camp program designed for children with asthma.

Healthcare Provider Signature

Printed Name of Healthcare Provider

Clinic or Office

(_____) _____
Telephone

Street Address

City State Zip Code

Would you volunteer at camp? ___ Y ___ N

Date

Please return to: By ____ / ____ / ____
