

STAPLE PHOTO HERE

FOR OFFICE USE ONLY

Scale: 1=Mild 2=Moderate 3=Severe

Asthma Ranking _____

Social/Emotional Ranking _____

Other Notes:

ASTHMA CAMP UNIVERSAL HEALTH FORM

A. GENERAL INFORMATION - to be completed by parents

NAME OF CHILD _____

PREFERS TO BE CALLED _____

Birthdate _____ Sex Female Male Age At Camp _____ Present grade (or recent past grade) _____

Name(s) of Parents (or Guardians)

Father _____ Phone: Home () _____ Work () _____ Cell () _____
 Email _____

Mother _____ Phone: Home () _____ Work () _____ Cell () _____
 Email _____

or Guardians _____ Phone Home () _____ Work () _____ Cell () _____
 Email _____

MAILING ADDRESS _____ City _____ State _____ Zip Code _____

Are parents living together? Yes No

Are there any custody or visitation restrictions? If so, describe:

IF NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY: (this must be filled out)

Name _____ Relationship to child _____ Phone() _____

Name _____ Relationship to child _____ Phone() _____

Who is your child's primary care MD?
 Pediatrician Family Practitioner Don't Know Other

If other: _____

Name of child's regular physician _____ Phone _____ Address _____

Does your child currently see an asthma specialist? Yes No
 If so, which type? Allergist Pulmonologist Don't Know

Name of child's asthma physician _____ Phone _____

Address _____

What does your child have for medical insurance?

PPO HMO Medic-Aid Medi-Cal None Don't Know

Name of Health Insurance Plan _____

Policy or Group Number _____

Has your child attended this Camp before? Yes No

If so, for how many sessions? _____sessions

Has your child attended other asthma camps? Yes No

If so, for how many sessions? _____sessions

Has your child ever been to an overnight camp? Yes No

T-shirt size: S M L XL

Family size _____

Family income _____

B. MEDICATIONS - to be completed by parent and preferably verified by physician

1. My child takes the following ASTHMA medications EVERY DAY:

X	Medication	Generic Name	Amount (puffs, tabs, caps, ampules, tsp, cc)	How often				Specific instructions
				1x/day	2x/day	3x/day	4x/day	
	Accolate 10 mg tab	Zafirlukast tab		1x/day	2x/day	3x/day	4x/day	
	Accolate 20 mg tab	Zafirlukast tab		1x/day	2x/day	3x/day	4x/day	
	Advair 100/50 mcg Discushaler	Fluticasone/Salmeterol Combination DPI		1x/day	2x/day	3x/day	4x/day	
	Advair 250/50 mcg Discushaler	Fluticasone/Salmeterol Combination DPI		1x/day	2x/day	3x/day	4x/day	
	Advair 500/50 mcg Discushaler	Fluticasone/Salmeterol Combination DPI		1x/day	2x/day	3x/day	4x/day	
	Advair HFA 45/21	Fluticasone/Salmeterol Combination MDI		1x/day	2x/day	3x/day	4x/day	
	Advair HFA 115/21	Fluticasone/Salmeterol Combination MDI		1x/day	2x/day	3x/day	4x/day	
	Advair HFA 230/21	Fluticasone/Salmeterol Combination MDI		1x/day	2x/day	3x/day	4x/day	
	AeroBid inhaler	Flunisolide MDI		1x/day	2x/day	3x/day	4x/day	
	Asmanex Twisthaler	Mometasone DPI		1x/day	2x/day	3x/day	4x/day	
	Azmacort inhaler	Triamcinoloneacetone MDI		1x/day	2x/day	3x/day	4x/day	
	Beclovent inhaler	Beclomethasone CFC MDI		1x/day	2x/day	3x/day	4x/day	
	Flovent 44 mcg inhaler	Fluticasone MDI		1x/day	2x/day	3x/day	4x/day	
	Flovent 110 mcg inhaler	Fluticasone MDI		1x/day	2x/day	3x/day	4x/day	
	Flovent 220 mcg inhaler	Fluticasone MDI		1x/day	2x/day	3x/day	4x/day	
	Foradil Aerolizer	Formoterol DPI		1x/day	2x/day	3x/day	4x/day	
	Intal inhaler	Cromolyn MDI		1x/day	2x/day	3x/day	4x/day	
	Intal neb solution	Cromolyn solution		1x/day	2x/day	3x/day	4x/day	
	Prednisone/prednisolone liquid 15mg/5ml	Prednisone/prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Prednisone/prednisolone liquid 5mg/5ml	Prednisone/prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Prednisone tabs 1 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tabs 2 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tabs 5 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tabs 10 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tabs 20mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Proventil Repetabs 4 mg	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Proventil Repetabs 8 mg	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Pulmicort 80 mcg Flexhaler	Budesonide DPI		1x/day	2x/day	3x/day	4x/day	
	Pulmicort 160 mcg Flexhaler	Budesonide DPI		1x/day	2x/day	3x/day	4x/day	
	Pulmicort 180 mcg Flexhaler	Budesonide DPI		1x/day	2x/day	3x/day	4x/day	
	Pulmicort 0.25 mg Respules	Budesonide suspension		1x/day	2x/day	3x/day	4x/day	
	Pulmicort 0.50 mg Respules	Budesonide suspension		1x/day	2x/day	3x/day	4x/day	

Pulmicort 1.0 mg Respules	Budesonide suspension		1x/day	2x/day	3x/day	4x/day
Q-Var 40 mcg inhaler	Beclomethasone HFA MDI		1x/day	2x/day	3x/day	4x/day
Q-Var 80 mcg inhaler	Beclomethasone HFA MDI		1x/day	2x/day	3x/day	4x/day
Serevent Discushaler	Salmeterol DPI		1x/day	2x/day	3x/day	4x/day
Singulair 4 mg sprinkle	Montelukast granules		1x/day	2x/day	3x/day	4x/day
Singulair 4 mg tab	Montelukast tab		1x/day	2x/day	3x/day	4x/day
Singulair 5 mg tab	Montelukast tab		1x/day	2x/day	3x/day	4x/day
Singulair 10 mg tab	Montelukast tab		1x/day	2x/day	3x/day	4x/day

(EVERY DAY Medications continued)

X	Medication	Generic Name	Amount (puffs, tabs, caps, ampules, tsp, cc)	How Often?				Specific instructions
	Symbicort 80 mcg inhaler	Budesonide/Formaterol MDI		1x/day	2x/day	3x/day	4x/day	
	Symbicort 160 mcg inhaler	Budesonide/Formaterol MDI		1x/day	2x/day	3x/day	4x/day	
	Theophylline time-release 100 mg tab	Theophylline tab		1x/day	2x/day	3x/day	4x/day	
	Theophylline time- release 200 mg tab	Theophylline tab		1x/day	2x/day	3x/day	4x/day	
	Theophylline time-release 300 mg tab	Theophylline tab		1x/day	2x/day	3x/day	4x/day	
	Tilade inhaler	Nedocromil MDI		1x/day	2x/day	3x/day	4x/day	
	Uniphyl 400 mg tab	Theophylline tab		1x/day	2x/day	3x/day	4x/day	
	Uniphyl 600 mg tab	Theophylline tab		1x/day	2x/day	3x/day	4x/day	
	Vanceril inhaler	Beclomethasone CFC MDI		1x/day	2x/day	3x/day	4x/day	
	Vospire 4 mg tab	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Vospire 8 mg tab	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Other			1x/day	2x/day	3x/day	4x/day	

Additional Specific Instructions:

2. The following ASTHMA medications are given ONLY IF NEEDED:

X	Medication	Generic Name	Amount (puffs, tabs, caps, ampules, tsp, cc)	How Often?				Specific instructions
				1x/day	2x/day	3x/day	4x/day	
	Albuterol inhal soltn	Albuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Albuterol inhaler	Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Albuterol syrup	Albuterol syrup		1x/day	2x/day	3x/day	4x/day	
	Albuterol tabs 2 mg	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Albuterol tabs 4 mg	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Alupent inhal soltn	Metaproterenol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Alupent inhaler	Metaproterenol MDI		1x/day	2x/day	3x/day	4x/day	
	Alupent syrup	Metaproterenol syrup		1x/day	2x/day	3x/day	4x/day	
	Alupent tab 5 mg	Metaproterenol tab		1x/day	2x/day	3x/day	4x/day	
	Alupent tab 10 mg	Metaproterenol tab		1x/day	2x/day	3x/day	4x/day	
	Atrovent inhal soltn	Ipratropium inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Atrovent inhaler	Ipratropium MDI		1x/day	2x/day	3x/day	4x/day	
	Brethaire inhaler	Terbutaline MDI		1x/day	2x/day	3x/day	4x/day	
	Brethaire tab	Terbutaline tab		1x/day	2x/day	3x/day	4x/day	
	Brethine inhaler	Terbutaline MDI		1x/day	2x/day	3x/day	4x/day	
	Brethine tab 2.5 mg	Terbutaline tab		1x/day	2x/day	3x/day	4x/day	
	Brethine tab 5 mg	Terbutaline tab		1x/day	2x/day	3x/day	4x/day	
	Bricanyl tab 2.5 mg	Terbutaline tab		1x/day	2x/day	3x/day	4x/day	
	Bricanyl tab 5 mg	Terbutaline tab		1x/day	2x/day	3x/day	4x/day	
	Bronkometer	Isoetharine MDI		1x/day	2x/day	3x/day	4x/day	
	Bronkosol	Isoetharine inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Bubbly Pred 5 mg/5 ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Combivent inhaler	Ipratropium/Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Decadron syrup	Dexamethasone syrup		1x/day	2x/day	3x/day	4x/day	
	Duoneb inhal soltn	Ipratropium/Albuterol combination inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Maxair Autohaler	Pirbuterol inhaler MDI		1x/day	2x/day	3x/day	4x/day	
	Medrol tab 2 mg	Methylprednisolone tab		1x/day	2x/day	3x/day	4x/day	
	Medrol tab 4 mg	Methylprednisolone tab		1x/day	2x/day	3x/day	4x/day	
	Medrol tab 8 mg	Methylprednisolone tab		1x/day	2x/day	3x/day	4x/day	
	Medrol tab 16 mg	Methylprednisolone tab		1x/day	2x/day	3x/day	4x/day	
	Medrol tab 24 mg	Methylprednisolone tab		1x/day	2x/day	3x/day	4x/day	
	Medrol tab 32 mg	Methylprednisolone tab		1x/day	2x/day	3x/day	4x/day	
	Metaprel inhal soltn	Metaproterenol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Metaprel inhaler	Metaproterenol MDI		1x/day	2x/day	3x/day	4x/day	
	Metaprel syrup	Metaproterenol syrup		1x/day	2x/day	3x/day	4x/day	
	Metaprel tab 5 mg	Metaproterenol tab		1x/day	2x/day	3x/day	4x/day	
	Metaprel tab 10 mg	Metaproterenol tab		1x/day	2x/day	3x/day	4x/day	

(IF NEEDED Medications continued)

X	Medication	Generic Name	Amount (puffs, tabs, caps, ampules, tsp, cc)	How Often?				Specific instructions
	Pediapred 5 mg/5 ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Prednisolone 5 mg/5 ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Prednisone liquid 5 mg/5 ml	Prednisone liquid		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 1 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 2 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 5 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 10 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 20 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prelone 5 mg/5 ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Prelone 15 mg/5ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	ProAir inhaler	Albuterol HFA MDI		1x/day	2x/day	3x/day	4x/day	
	Proventil inhal soltn	Albuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Proventil HFA inhaler	Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Proventil syrup	Albuterol syrup		1x/day	2x/day	3x/day	4x/day	
	Proventil tab 2 mg	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Proventil tab 4 mg	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Tornalate HFA inhaler	Bitolterol MDI		1x/day	2x/day	3x/day	4x/day	
	Ventolin inhal soltn	Albuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Ventolin HFA inhaler	Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Ventolin syrup	Albuterol syrup		1x/day	2x/day	3x/day	4x/day	
	Ventolin tab 2 mg	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Ventolin tab 4 mg	Albuterol tab		1x/day	2x/day	3x/day	4x/day	
	Xopenex inhal soltn 0.32 mg	Levalbuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Xopenex inhal soltn 0.65 mg	Levalbuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Xopenex inhal soltn 1.25 mg	Levalbuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Xopenex MDI	Levalbuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Other			1x/day	2x/day	3x/day	4x/day	

Additional Specific Instructions:

3. Other medications that your child takes:

Medication	Strength	Amount (puffs, tabs, caps, ampules, tsp, cc)	Regular or as needed?	How often?				Specific Instructions
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	

Additional Specific Instructions:

Is your child on allergy injections? ___ Yes ___ No

****NOTE:** No allergy shots will be given at camp (unless there are special circumstances).

Does your child use a spacer or assisting device with his/her inhaler? ___ Yes ___ No

If so, which one? _____

Is there any medication treatment you prefer not be used at camp for you child?

Does your child have a specific Asthma Action Plan? ___ Yes ___ No

If so, please attach to this form.

C. HISTORY OF ASTHMA - to be completed by parent and preferably verified by physician

1) How long has your child had asthma? ____ years

2) Within the past 5 years:

A) Has your child been admitted to the hospital for asthma? ____ Yes ____ No How many times total? ____
How old was he or she each time? ____

B) Has your child been in an intensive care unit for asthma? ____ Yes ____ No How many times total? ____
How old was he or she each time? ____

3) Within the past three months (on the average):

A) How many nights per week, on the average, does your child wake up because of asthma or coughing? ____ nights
per week

B) How much does your child's asthma interfere with exercise?
____ None ____ Some ____ Moderate ____ A lot

4) Within this past year only, how many times did your child need to (list number of times)

A) Stay home from school because of asthma? ____ days

B) Be taken to the doctor's office because of difficulty with his or her asthma (not including routine office visits)?
____ times

C) Be taken to the emergency room or urgent care clinic because of asthma difficulty? ____ times

D) Be admitted to the hospital for asthma? ____ Yes ____ No

How many times total? ____

How old was he or she each time? ____

E) Be in an intensive care unit for asthma? ____ Yes ____ No How many times total? ____

How old was he or she each time? ____

5) How many times (in the past year only) have oral corticosteroids been used for the control of your child's asthma?

(Note: Oral corticosteroids are medications taken by mouth in either pill or liquid form, and are usually used when other medications cannot adequately control asthma symptoms. Names of oral corticosteroids include: PILLS: Prednisone, Medrol, Deltasone, Decadron and others LIQUIDS: PediaPred, Prelone, Liquidpred, OraPred, BubblyPred and others.)

____ courses of oral corticosteroids have been taken in the past year.

Date of most recent course? ____

6) Who is responsible for giving your child's asthma medication at home?

____ Child ____ Parent ____ Both

7) Does your child use a peak flow meter? ____ Yes ____ No If yes, what brand? _____

If yes, what is your child's normal reading? _____

Does your child use it routinely? ____ Yes ____ No

If so, how often? ____ time(s) a day ____ time(s) a week

8) On a scale of 0-10, how bad (severe) has your child's asthma been over the last year? (CIRCLE ONE NUMBER ONLY!)

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

Describe any emotional effects you have observed in your child due to asthma:

D. HISTORY OF ALLERGIES - to be completed by parent and preferable verified by physician

Is our child allergic to any MEDICATION? (Penicillin, sulfa, etc.)? ___ Yes ___ No

If yes, please list:

Medication Name	Reactions* <i>(be specific with the symptoms, how severe, when they start, etc.)</i>	Age of Last Reaction

Is our child allergic to any FOODS? ___ Yes ___ No

If yes, please list:

Food Name	Reactions* <i>(be specific with the symptoms, how severe, when they start, etc.)</i>	Age of Last Reaction

Is our child allergic to any ANIMALS? ___ Yes ___ No

If yes, please list:

Animal	Reactions* <i>(be specific with the symptoms, how severe, when they start, etc.)</i>	Age of Last Reaction

Is our child allergic to any INSECTS? ___ Yes ___ No

If yes, please list:

Insect	Reactions* <i>(be specific with the symptoms, how severe, when they start, etc.)</i>	Age of Last Reaction

**Reactions include: Severe total body reaction (anaphylaxis); shock; skin problems (hives, redness, blistering, itchy skin, swelling); breathing problems (wheeze, cough, chest tightness); mouth problems (swollen lips, rash, tongue swelling, itchy); throat problems (swollen, itchy, scratchy); eye problems (swollen, itchy, watery); nose problems (itchy, runny, stuffy, sneezing); intestinal problems (abdominal pain, vomiting, diarrhea); behavior/sleep problems (stimulation, hyper, strange behavior, sleepiness, trouble sleeping)*

Was emergency treatment needed for any of the reactions listed above (e.g. 911, ER visit, Urgent Care, EpiPen)? ___ Yes ___ No

If so, explain:

E. OTHER INFORMATION - to be completed by parent

Has your child had the following illnesses?

Measles? Yes No Rubella? Yes No
Chicken Pox? Yes No Mumps? Yes No

Date of most recent tetanus booster: _____

DPT, Polio and MMR immunizations up-to-date? Yes No

Specifically, does your child have any of the following problems?

Convulsive Disorders? Yes No Hyperactivity? Yes No
Diabetes? Yes No Heart Disease? Yes No
Fainting? Yes No Bedwetting? Yes No
Discipline Problems? Yes No Sleepwalking? Yes No
Constipation? Yes No Learning Disability? Yes No
Depression? Yes No Obsessive Compulsive Disorder? Yes No
Attention Deficit Disorder? Yes No

Are there any other medical problems or conditions your child has that the camp should know about? Yes No

If yes to any of the above questions, explain here:

Has your child ever camped out with the family? Yes No

If yes, were there any problems? Yes No

If yes, explain:

Has your child been to the mountains recently? Yes No

Any previous problems with altitude? Yes No

If yes, explain:

Has your child ever been away from home and parents for more than a few days? Yes No

If so, were there any problems? _____

Do you anticipate any problems with homesickness at asthma camp? _____

Does your child feel embarrassed at school or in public if he/she has to take an inhaler or nebulizer treatment? Yes No

Do you anticipate any activity restrictions? Yes No

If so, explain: _____

Are there any present physical education restrictions at school? Yes No

If so, explain: _____

Is there anything else you feel camp staff should know about your child? Yes No

If so, explain:

HOW DID YOU HEAR ABOUT ASTHMA CAMP?

Please check one:

Healthcare Provider's Office Social Worker Radio Internet/Web Site
 School Nurse TV Newspaper Magazine
 Friend Called or wrote to Other _____
 Previous camper or camp staff ALA or AAFA

How often over the past 4 weeks has/have:	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Your child complained of being short of breath					
Exertion (such as running) made your child breathless					
Your child coughed at night					
Your child been woken up by wheezing and coughing					
Your child stayed indoors because of wheezing or coughing					
Your child's education suffered due to his/her asthma (during school)					
Your child's asthma interfered with his/her life					
Asthma limited your child's activities					
Taking his/her inhaler or other treatments interrupted your child's life					
You had to make adjustments to family life because of your child's asthma					

PARENT'S AUTHORIZATION

Date Rec'd _____

Both sides must be completed for application to be considered

PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in Camp _____ (*insert Camp Name here*), held _____ (*insert date here*), sponsored by _____ (*insert sponsor name here*), as parent/guardian I hereby release the Association, its Incorporators, Physicians, Board Members, Officers, Employees, Agents, Independent Contractors and Volunteer Workers from any liability for injuries which are sustained during the camp, **including any necessary transportation**. The child herein described has permission to engage in all scheduled activities except as noted by the physician or parent/guardian. I hereby give permission to the camp physician to initiate and provide any necessary treatments, including transporting to the nearest certified emergency facility. If hospitalization is required, the child is to be referred to an appropriate physician and all treatments will be at my expense.

PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE

I do hereby acknowledge and authorize Camp _____ (*insert Camp Name here*) and _____ (*insert sponsoring organization(s) here*) to take and use photographs, video and written comments of or by my child for promotional and informational materials. Further, I agree to release and discharge _____ (*insert sponsoring organization(s) here*) and its sponsors from any and all liability in connection with the use of such photographs, videos and written comments of or by my child.

RELEASE FOR TRANSPORT HOME

At the conclusion of camp, the Camp Staff may release my child to myself or to the individual(s) designated below. Under no circumstances will your child be released to anyone not specified by you. Picture ID may be required.

Name _____ Relationship to child _____ Phone () _____
Please Print
Signature of Parent or Guardian _____ Date ____/____/____ Work Phone () _____

AUTHORIZATION TO RELEASE MEDICAL DATA

I do hereby authorize Camp _____ (*insert Camp Name here*) and _____ (*insert sponsoring organization(s) here*) to release medical data for the purpose of compiling and assessing national asthma medical information. I understand that all data will be analyzed in aggregate form protecting the confidentiality of my child.

Name _____ Relationship to child _____ Phone () _____
Please Print
Signature of Parent or Guardian _____ Date ____/____/____ Work Phone () _____

CAMPER CODE OF CONDUCT

(Please review with your child)

It is our hope that everyone that participates in our program will have a positive experience that will last a lifetime. To help everyone get the most out of their camp experience, we have set up a list of ground rules to help parents and children understand what we expect at camp. We recognize the special needs of our campers and will as much as possible; individualize the rules according to the needs and abilities of each camper.

Camp has four basic rules that we explain to the children and also post in the cabins. We have these rules so that everyone can be assured of a positive experience.

- ∞ **Respect yourself, others and property.** This means abusiveness toward others or using inappropriate language, fighting, stealing, etc. It also covers property damage, graffiti or vandalism. Respect yourself, refers to keeping your things picked up, personal hygiene and taking your medication on time.
- ∞ **Participate in camp activities.** It is camp's responsibility to know where all the campers are at all times. We ask campers to be at all activities unless excused by staff. Campers cannot be left alone in their cabin.
- ∞ **Follow directions.** There are a lot of fun things to do at camp but every activity has rules so we can operate the activity safely and appropriately. We ask the campers to follow staff direction during these activities.
- ∞ **No put-downs.** Examples of this would include teasing, name-calling, racial slurs or inappropriate practical jokes.

If we do have a problem with inappropriate behavior, we have a camper behavior response policy. The counselor will start by giving the child a warning, then a time-out with an explanation and discussion on what is causing the problem. If the counselor needs help, a behavioral specialist or the designated healthcare team supervisor on site will work with the child to help avoid further problems. We will also call home to find out if the parents have any suggestions on ways to deter the inappropriate behavior. As a last resort, we may need to send a child home. Sometimes in the case of severe homesickness or if misbehavior could cause immediate harm to themselves or others, we reserve the right to immediately ask that the child be removed from camp.

It is our hope that each child will go home with great memories of camp. These rules are designed to protect the camper's experience so that one unruly child won't ruin the experience for the rest. If you have any questions or comments, please feel free to call. It is our mission to provide a quality experience for everyone.

I understand and accept that my child must abide by the Camper Code of Conduct

Parent's Signature

I agree to abide by the Camper Code of Conduct

Camper's Signature

____/____/____
Date

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 ____ / ____ / ____

HISTORY

Immunization Dates:

DT _____ Hepatitis B _____

MMR _____ Chicken Pox _____

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)

9. How would you rate the child's level of asthma control?

Well controlled

Not well controlled

Very poorly controlled

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 ____/____/____
