

STAPLE PICTURE HERE
DO NOT TAPE
PICTURE SHOULD HAVE
BEEN TAKEN WITHIN
THE
LAST YEAR
IF YOU HAVE AN
ELECTRONIC PICTURE
PLEASE SEND TO
CTINO@MAC.COM



FOR OFFICE USE ONLY

Scale: 1=Mild 2=Moderate 3=Severe _____
 Asthma Ranking _____
 Social/Emotional Ranking _____
 Other Notes _____

Date Rec'd _____

2019 CAMPER HEALTH FORM

GENERAL INFORMATION *(to be completed by parents)*

Camper Name _____ Birthdate ____ / ____ / ____
Last First Middle Initial

Sex: Male Female Nickname _____ Age at Camp _____

Grade Entering in Fall _____ What school will they attend in 2019-2020 _____

T-shirt size: YM (youth medium) YL (youth large) AS(adult small) AM(adult medium) AL (adult large)
 AEL (adult extra large)

EMERGENCY CONTACT INFORMATION

Father: Check if Primary Residence **Mother:** Check if Primary Residence **Guardian(s):** Check if Primary Residence

Last First Last First Last First

Address Address Address

City State Zip City State Zip City State Zip

Home Telephone Home Telephone Home Telephone

Work Telephone Work Telephone Work Telephone

Cell phone Cell phone Cell phone

Email Email Email

Who will be the primary contact while your child is at camp? _____ Best # to call? (_____) _____

Who is (are) the legal guardian(s) for this child? _____

Are parents living together? **Yes No**

If no, are there any custody or visitation restrictions? **Yes No** If yes, please describe _____

If not available in an emergency, please notify (this must be filled out, only those listed will be able to pick up child)

Name _____ Relationship to child _____ Phone (_____) _____

Name _____ Relationship to child _____ Phone (_____) _____

CAMPER INFORMATION

Has your child:

Attended this camp before? **Yes No** Please circle years 13 14 15 16 17 18
Attended other asthma camps? **Yes No** Name and location _____
Attended other **residential** non-asthma camps? **Yes No** Name and location _____
Camped with family or others? **Yes No** Explain _____
Been to the mountains recently? **Yes No**
Any previous problems with altitude? **Yes No** Explain _____
Ever been away from home and parents for a few days? **Yes No** Explain _____
Suffered from homesickness? **Yes No** Explain _____
Been placed on any activity restrictions? **Yes No** Explain _____
Had any recent changes in their family? **Yes No** Explain _____

HEALTHCARE PROVIDER INFORMATION

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 _____

Do you have health insurance for your child? Yes No

Name of Health Insurance Plan _____

Policy/Group # _____ Member #/ID # _____

CAMPER HEALTH HISTORY

(to be completed by camper's 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

Does your child have any of the following health concerns?

Heart Disease..... Yes No

Fainting..... Yes No

Sleepwalking..... Yes No

Diabetes..... Yes No

Discipline Problems..... Yes No

Hyperactivity..... Yes No

Convulsive Disorders..... Yes No

Bedwetting..... Yes No

Constipation..... Yes No

Learning Disability..... Yes No

ADD/OCD (circle)..... Yes No

Hives..... Yes No

Drug Allergies..... Yes No

Frequent colds..... Yes No

Exzema..... Yes No

Frequent bronchitis..... Yes No

Hay fever..... Yes No

Other _____

If you answered yes to any of the above, please explain: _____

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

Are there other medical conditions, other than asthma and allergies, for which your child is being treated or followed by a health care provider? Yes No If yes, please explain: _____

Are there any religious beliefs that camp leaders should be aware of that would alter your child's activities at camp?

Yes No If yes, please explain? _____

Who is responsible for giving your child asthma medication at home? Child Parent Other _____

Does your child use a peak flow meter? Yes No If yes, what is your child's normal reading? _____

Does your child have a written asthma action plan? Yes No If yes, please attach.

What brand of peak flow meter? _____ **Do they use it regularly?** Yes No

On a scale of 0 to 10, how would you rank your child's asthma? (Circle only one number!)

(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 _____

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					

ALL MEDICATIONS

Please include asthma and non-asthma medications

(to be completed by parent/guardian)

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

HISTORY OF ASTHMA

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

Date of most recent course? ____

(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.)

ALLERGY INFORMATION

Is your child allergic to any:

MEDICATION (penicillin, sulfa, etc.)? Yes No

Medication Name	(be specific with the symptoms, how severe, when they start, etc.)	Age of Last Reactions*
_____	_____	_____
_____	_____	_____
_____	_____	_____

FOODS? Yes No

Food	(be specific with the symptoms, how severe, when they start, etc.)	Age of Last Reactions*
_____	_____	_____
_____	_____	_____
_____	_____	_____

ANIMALS? Yes No

Animal	(be specific with the symptoms, how severe, when they start, etc.)	Age of Last Reactions*
_____	_____	_____
_____	_____	_____
_____	_____	_____

INSECTS? Yes No

Insect	(be specific with the symptoms, how severe, when they start, etc.)	Age of Last Reactions*
_____	_____	_____
_____	_____	_____
_____	_____	_____

*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 YES , explain: _____

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 your child?

Has your child recently been exposed to any contagious diseases? Yes No

If yes, what disease and when? _____

Is your child frightened by anything? Yes No If yes, what? _____

CAMPER'S COMMITMENT

I want to help make camp a fun experience. I agree to follow camp rules. I will do my best to make this a good experience for my fellow campers and myself. I understand that if I do not live up to this promise, I may be sent home from camp (without a refund).

SIGN HERE X

Camper's Signature

_____/_____/_____
Date

SIGN HERE X

Parent's/Guardian's Signature

_____/_____/_____
Date

PARENT'S AUTHORIZATION

Date Rec'd _____

All information must be completed for application to be considered

PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in Camp AsthmaCadabra, held August 1- August 4, 2019 sponsored by American Lung Association in Pennsylvania, 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 and from 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.

SIGN HERE X

Parent's/Guardian's Signature

PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE

I do hereby acknowledge and authorize the American Lung Association in Pennsylvania & Max & Lorraine Foundation's Camp AsthmaCadabra 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 American Lung Association in Pennsylvania 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

SIGN HERE X

Signature of Parent or Guardian

_____/_____/_____
Date

Work Phone (_____) _____

AUTHORIZATION TO RELEASE MEDICAL DATA

I do hereby authorize Camp AsthmaCadabra and American Lung Association in Pennsylvania 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

SIGN HERE X

Signature of Parent or Guardian

_____/_____/_____
Date

Work Phone (_____) _____

HOW DID YOU HEAR ABOUT ASTHMA CAMP?

Please circle one:

- | | | | |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Healthcare Provider's Office | <input type="checkbox"/> Social Worker | <input type="checkbox"/> Radio | <input type="checkbox"/> Internet/Web Site |
| <input type="checkbox"/> School Nurse | <input type="checkbox"/> TV | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Magazine |
| <input type="checkbox"/> Friend | <input type="checkbox"/> Called or wrote to
ALA or AAFA | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Previous camper or camp staff | | | |

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. In addition for overnight campers, at the end of the day campers are to comply with curfew and meal times.
- **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. In addition, campers should dress appropriately for camp – sneakers, shorts, t-shirts, sweatshirts, etc.
- **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 and if my child does not that it is my responsibility to go get my child from camp in a timely fashion.

SIGN HERE X _____

Parent's Signature

I agree to abide by the Camper Code of Conduct SIGN HERE X _____

Camper's Signature

_____/_____/_____
Date

ASTHMA CAMP MEDICAL HISTORY AND PHYSICAL EXAMINATION

(To be completed by the child's healthcare provider)

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

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

Date of last physical exam ____ / ____ / ____

Last PFT Date: _____ FEV1 _____ %

HISTORY

MANDATORY 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

HISTORY OF ALLERGIES - to be 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: _____

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

Date

Would you volunteer at camp? Y N

Please return to:
By ____/____/____