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 ____________

2018 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 2018-2019 ____________________

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

____
Last First
____
Address
____
City State Zip
(______)________
Home Telephone
(______)________
Work Telephone
(______)________
Cell phone
____
Email

Mother: ☐ Check if Primary Residence

____
Last First
____
Address
____
City State Zip
(______)________
Home Telephone
(______)________
Work Telephone
(______)________
Cell phone
____
Email

Guardian(s): ☐ Check if Primary Residence

____
Last First
____
Address
____
City State Zip
(______)________
Home Telephone
(______)________
Work Telephone
(______)________
Cell phone
____
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 12 13 14 15 16 17
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**
Diabetes.................. ☐ **Yes** ☐ **No**
Convulsive Disorders ..... ☐ **Yes** ☐ **No**
Learning Disability......... ☐ **Yes** ☐ **No**
Drug Allergies………….. ☐ **Yes** ☐ **No**
Frequent bronchitis……. ☐ **Yes** ☐ **No**
Fainting .... ☐ **Yes** ☐ **No**
Discipline Problems........ ☐ **Yes** ☐ **No**
Bedwetting................ ☐ **Yes** ☐ **No**
ADD/OCD (circle).......... ☐ **Yes** ☐ **No**
Frequent colds………… ☐ **Yes** ☐ **No**
Hay fever………………. ☐ **Yes** ☐ **No**
Sleepwalking..... ☐ **Yes** ☐ **No**
Hyperactivity..... ☐ **Yes** ☐ **No**
Constipation..... ☐ **Yes** ☐ **No**
Hives…………... ☐ **Yes** ☐ **No**
Exzema……….. ☐ **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 your 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 take 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 corticosterioids 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).

Camper's Signature ______________________ Date ____/____/____

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 2**-** August 5, 2018 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.

____
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'd 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 ______________________ (Please Print) Relationship to child ____________ Phone (   ) ____________

______________________ 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 ______________________ (Please Print) Relationship to child ____________ Phone (   ) ____________

______________________ Signature of Parent or Guardian ____/____/____ Date Work Phone (   ) ____________

HOW DID YOU HEAR ABOUT ASTHMA CAMP?

Please circle one:

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

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 fell 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. ______________________________

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 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**______________%

MANDATORY 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)

9. How would you rate the childs level of asthma control? ___Well Controlled __Not Well Controlled __Very poorly controlled

LIST OF MEDICINES FOR CHILD

To be filled out by Nurse Practioner/Physician

Medicine	Strength	Dosage	Frequency

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

Is our child allergic to any FOODS? ____Yes ____No
If yes, please list:

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

Is our child allergic to any ANIMALS? ____Yes ____No
If yes, please list:

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

Is our child allergic to any INSECTS? ____Yes ____No
If yes, please list:

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

____________ **Would you volunteer at camp?** ☐**Y** ☐**N**
Date

Please return to:

By ____/______/______