

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 _____

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	

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

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 _____ / _____ / _____

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)

MEDICATIONS

Please include asthma and non-asthma medications

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	

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

Clinic or Office

Street Address

Printed Name of Healthcare Provider

(_____) _____
Telephone

City

State

Zip Code

<p>Please return to:</p> <p>By _____ / _____ / _____</p>
