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 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? *(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* *(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:

____

____

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 embarassed 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 ALA or AAFA	___ Other ___________________________	
___ 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.

- **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 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

____
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	

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 PROVDER'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

Please return to:

By ____/____/____