

# Peninsula Puffers Asthma Camp 2012- Application

*Camp is for children, ages 7 to 14, who take medications daily for their asthma.*

**Online Registration is available at [www.aafaalaska.com](http://www.aafaalaska.com)**

**CAMP DATES: July 8 to July 13, 2012**

**Deadline to apply: June 15, 2012** (Feel free to photocopy application as needed)

*Please Mail Application and camp fee of \$125.00 to*

Peninsula Puffers Asthma Camp

C/O AAFA Alaska

P.O. Box 201927. Anchorage, AK 99520

**Page 1, 2 & 3 completed by parent/ guardian. Page 4 & 5 completed by healthcare provider (physician)**

## **PART 1: A- IDENTIFICATION (please print clearly)**

Camper's Full Name: \_\_\_\_\_  
Last First Middle  
Gender: Female Male Birthday: \_\_\_/\_\_\_/\_\_\_ Age by August 2009: \_\_\_\_\_ Grade in Fall 09: \_\_\_\_\_  
Ethnicity: African American Asian/Pacific Islander Caucasian Latino Native American Other  
T-shirt size (for campers) Child Size M L or Adult Size S M L XL

## **PART 1: B- EMERGENCY CONTACT INFORMATION**

**Father:** Primary Residence

**Mother:** Primary Residence

**Guardian:** 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

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Work Telephone

\_\_\_\_\_  
Work Telephone

\_\_\_\_\_  
Work Telephone

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

E-mail: \_\_\_\_\_

**Other Emergency Contacts:**

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

## **PART 1: C- HEALTHCARE INSURANCE/ PROVIDER INFORMATION**

Health Insurance Carrier: \_\_\_\_\_ Insurance Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

**PART 1: D- GENERAL INFORMATION**

**YES NO**

Has your child attended an asthma camp? If yes, please list years: \_\_\_\_\_

Does your child get homesick/ have nightmares/ bed wets? If yes, explain \_\_\_\_\_

Has your child been diagnosed with ADD/ ADHD/ OCD/ being hyperactive, depressions, panic disorder? If yes, list medications: \_\_\_\_\_ Physician prescribing: \_\_\_\_\_

Does your child have any of the following chronic conditions: If yes, please  all that apply  
 Sickle Cell  Hepatitis  Diabetes  Seizure Disorder  Other \_\_\_\_\_

Has your daughter started her menstrual cycle? If yes, does she take medications, list medications: \_\_\_\_\_

This child has additional social, mental or emotional needs:  
 If yes, explain: \_\_\_\_\_

What additional information should your child's cabin counselor know that will make your child's adjustment smoother at camp?  
 \_\_\_\_\_

**IMMUNIZATION:** (You must complete all dates to apply to camp)

Most recent Booster/ Tetanus/ Diptheria Shot \_\_\_\_/\_\_\_\_/\_\_\_\_ Chicken Pox Shot \_\_\_\_/\_\_\_\_/\_\_\_\_

If not vaccinated for chicken pox, has your child ever had chicken pox?  Yes  No

**PART 1: E- ASTHMA/ ALLERGY INFORMATION**

How long has your child had asthma? \_\_\_\_\_ years

How often does your child used Albuterol to relieve asthma symptoms?

Once daily  Less than 2 times/week  More than 3 times/week

Within the past 12 months, has your child been:

Admitted to the hospital for asthma  Yes  No How many times? \_\_\_\_\_

To the ER or "Urgent Care" center for asthma  Yes  No How many times? \_\_\_\_\_

Does your child record peak flow rate?  Yes  No What is usual rate? \_\_\_\_\_

Has your child been instructed to adjust medicines according to peak flow rates and "symptoms" rate?  Yes  No

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

Does your child know how to use the following items properly? (please  all that apply)

Meter dose inhaler  Spacer  Peak Flow Meter  Nebulizer  Does not use inhaler medications

Does your child have the following allergies/hypersensitivity? ( please  all that apply)

Food  Medicine  Cold  Fog  
 Dampness  Altitude  Skin contactants  Inhalants ( i.e. dust, pollens, danders)

If any of the above items were checked, please list type(s) of food, medicine, etc.

<u>TYPE OF FOOD/MEDICINE</u>	<u>REACTION (be specific)</u>	<u>AGE OF LAST REACTION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medications:** (Please list ALL medications including over-the-counter or nonprescription drugs taken routinely. Send enough medication to last the entire time at camp. All medications MUST be in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage and the frequency of administration. Your description of the medication times and dosages MUST match those on the container.)

- This camper does not take any medications on a regular basis.
- This camper takes the following medication during the school year, but will not continue it at camp \_\_\_\_\_
- This camper takes routine medication (including non-prescription, vitamins, ointments/creams) as follows:

<i>Medication</i>	<i>Dosage</i>	<i>Times taken each day</i>	<i>Reason for medication</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PARENT'S AUTHORIZATION**

I consent to my child being photographed, videotaped or interviewed for the purpose of recording the camp experience and understand that this may be used for publicity, fundraising, or other purposes (ie. website/brochures). Neither the Camp nor the Medical Staff assumes any other responsibilities.

**Over-the-Counter Medications:**

Camp Fire USA keeps the following over-the-counter medications in stock for use in treating campers with illnesses/injuries occurring at camp: Tylenol, Benadryl, Robitussin, Triaminic, Immodium, Maalox, milk of magnesia, cough drops, hydrocortisone cream, calamine and Caladryl lotion, antiseptic ointments and sprays, burn gel, bug spray. These medications may be dispensed to your child as deemed necessary in accordance with physician-approved treatment procedures. Please list any over-the-counter medications that you DO NOT want administered to your child. \_\_\_\_\_

Is camper able to swallow pills?     YES             NO

**CONSENT FOR MEDICAL TREATMENT:**

This health history is correct and complete. I understand that failure to disclose accurate information may result in my child's dismissal from the program. I hereby give permission to the camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering X-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I also give permission to the treating physician or facility to release pertinent medical information to the camp nurse or director. I give my consent for nurses/respiratory therapist to give my child over the counter and asthma and allergy medications as needed.

**HARMLESS CLAUSE:**

I understand that even though Camp Fire USA collects information, it is impossible to prevent every foreseeable and unforeseeable situation that may result in injury or death as a participant in this program. I do hereby release Camp Fire USA Alaska Council, its employees, agents, and camp staff from all claims, demands, actions or causes of actions for any sort of injuries sustained during the period covered by this release whether such injuries occur on or off the camp property. I further agree to release Central Peninsula Hospital and the Asthma & Allergy Foundation of America, Alaska Chapter, their employees, agents, and camp staff from all claims, demands, actions or causes of actions for any sort of injuries sustained during the period covered by this release whether such injuries occur on or off the camp property.

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**PART 2: Must be completed by the child's healthcare provider (physician)**

Child's Name: \_\_\_\_\_  
Date of last physical exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Height:\_\_\_\_ Weight:\_\_\_\_ Blood Pressure:\_\_\_\_  
Were there any abnormal findings? Yes No If yes, please explain: \_\_\_\_\_

**PART 2: A- GENERAL MEDICAL HISTORY**

Is this patient under your regular care? Yes No **Is patient up to date with Immunizations?** Yes No  
Date of last appointment \_\_\_\_/\_\_\_\_/\_\_\_\_

Does this patient have any of the following problems? (please  all that apply)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Convulsive disorders  | <input type="checkbox"/> Discipline Problems | <input type="checkbox"/> Skin Disease     | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Orthopedic            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Bedwetting       | <input type="checkbox"/> Constipation        |
| <input type="checkbox"/> Sleep Problem         | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Immunodeficiency | <input type="checkbox"/> HIV Infection       |
| <input type="checkbox"/> TB                    | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Fainting         | <input type="checkbox"/> OCD                 |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> ADD                 | <input type="checkbox"/> Hyperactivity    | <input type="checkbox"/> Other               |

If any of the above has been checked, please explain: \_\_\_\_\_  
\_\_\_\_\_

Contraindication to use of steroids or other medication: \_\_\_\_\_

Does the Camp Medical Staff need to be aware of any of the following?

**YES NO**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Known medical problems, besides asthma?                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Known behavioral or psychological issues?                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Foods that must be eliminated from this patient's camp diet?          |
| <input type="checkbox"/> | <input type="checkbox"/> | Specific medication issues?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Restrictions/limitations on participation any asthma camp activities? |

If any of the above has been checked "YES", please explain: \_\_\_\_\_  
\_\_\_\_\_

**PART 2: B- ALLERGY HISTORY**

What significant allergic conditions(s) does this patient have? (please  all that apply)

- Allergic Rhinitis  Atopic Dermatitis  Chronic/Recurrent Sinusitis  Anaphylaxis  Allergic GI disturbance

Is this patient allergic to any:

Yes No **MEDICATION?**

List Medications	Reaction	Age of Reaction
_____	_____	_____
_____	_____	_____

Yes No **FOOD?**

List Food	Reaction	Age of Reaction
_____	_____	_____
_____	_____	_____

Yes No **OTHERS** (i.e. bees, wasps, stings, dust mites, molds, pollens, animals)?

List Other Source	Reaction	Age of Reaction
_____	_____	_____
_____	_____	_____

## PART 2: C- ASTHMA HISTORY

Based on NIH's guidelines severity of classification, how would you rate this patient's asthma?

(please  one cell in each column that best describes this patient)

	CLASSIFY SEVERITY Clinical Features Before Treatment			TREATMENT	
	Symptoms	Night time Symptoms	Lung Function	Long Term	Quick Relief
<input type="checkbox"/> STEP 4 Severe Persistent	<input type="checkbox"/> Continuous limited physical activity. Frequent exacerbations	<input type="checkbox"/> Frequent, often 7 times/ wk	<input type="checkbox"/> FEV or PEF <60% predicted. PEF variability >30%	<input type="checkbox"/> High Dose MDI steroid, Long acting bronchodilators. Oral steroid.	<input type="checkbox"/> Beta 2 specific agonist MDI
<input type="checkbox"/> STEP 3 Moderate Persistent	<input type="checkbox"/> Daily Exacerbations affect activity. Exacerbations ≥ 2 times a week; may last days	<input type="checkbox"/> >1 time/ week, but not nightly	<input type="checkbox"/> FEV or PEF >60% to <80% predicted. PEF variability >30%	<input type="checkbox"/> Medium Dose MDI steroid, and/or long acting bronchodilators.	<input type="checkbox"/> Beta 2 specific agonist MDI
<input type="checkbox"/> STEP 2 Mild Persistent	<input type="checkbox"/> >2 times/ wk. but not daily Exacerbations may affect activity	<input type="checkbox"/> 3-4 times/ month	<input type="checkbox"/> FEV or PEF ≥80% predicted. PEF variability 20% to 30%	<input type="checkbox"/> Low Dose MDI steroid or other anti-inflammatory drugs	<input type="checkbox"/> Beta 2 specific agonist MDI
<input type="checkbox"/> STEP 1 Mild Intermittent	<input type="checkbox"/> ≤2 times/ wk. Asymptomatic & normal PEF between exacerbations. Exacerbations brief, intensity may vary.	<input type="checkbox"/> ≤ 2 times/ month	<input type="checkbox"/> FEV or PEF ≥80% predicted. PEF variability < 20%		<input type="checkbox"/> Beta 2 specific agonist MDI

YES  NO In the past year, has this patient been to "Urgent Care" and/or ER due to asthma?  
If yes, how many times? \_\_\_\_\_

YES  NO In the past year, have there been any hospitalizations because of asthma?  
If yes, how many times? \_\_\_\_\_

YES  NO In the past year, has this patient required oral steroids? Dosage \_\_\_\_\_  
If yes, how many times? \_\_\_\_\_ Date of most recent course \_\_\_\_/\_\_\_\_/\_\_\_\_

### Current Medications:

DRUG	Strength	Dosage	Frequency	Syrup	Caplet	Tablet	Inhaler	Nebulizer
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

### 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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Clinic or Office Address

\_\_\_\_\_  
Medical License #

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
City/State/Zip Code

YES  NO Would you like more information about the Asthma & Allergy Foundation of America (AAFA)?  
 YES  NO Are you interested in volunteering for Asthma Camp?

Peninsula Puffers Asthma Camp  
Central Peninsula Hospital & AAFA Alaska Chapter  
Release of Liability/Hold Harmless Form

I, the parent/legal guardian of \_\_\_\_\_, understand that my child will be participating in activities that have inherent risks and may need transportation to and from camp and to and from camp activities. I understand that activities and travel may include risk of injury. I understand that these risks include, but are not limited to, death and severe bodily injury. I also understand that these risks could lead to serious impairment of my child's future ability to earn a living, engage in business, and generally enjoy life. Because of the dangers involved, I understand the importance of any and all instructions for program activities and the use of safety belts, not distracting the driver, no standing up or excessive behavior and any other driver-imposed rules, and agree to instruct my child to obey all instructions given.

In consideration for allowing the participation of my child, I hereby assume all the risks associated with program and travel and agree to hold Central Peninsula Hospital and AAFA Alaska Chapter, their volunteers, employees, or agents harmless from any and all liability, causes of action, deaths, claims, or demands of any nature which may arise in connection with my child's travel to, from and during camp or its activities.

In addition, it is understood that Camp Fire USA Alaska Council attempts to provide adequate supervision, but that due to the nature of camp, there may be times when my child has minimum supervision. My child has permission to engage in all camp activities except as noted by the physician or parent/guardian.

In consideration for my child being allowed to attend camp, I shall indemnify and hold harmless Central Peninsula Hospital and AAFA Alaska Chapter and their employees, volunteers, or agents from and against any losses, costs, damages, expenses, including attorney's fees arising out of or resulting from claims or suits, by or on the behalf of any persons, for any injury to my child, including death, or for any damages to my child's property occurring during the course of my child's participation while at camp alleged or claimed to have been caused, in whole or in part, or contributed to, by any act or omission of any of the indemnities identified herein. The terms of this agreement serve as a release.

In signing this form, I certify my understanding of this form and agree to instruct my child to abide by all of the instructions given to my child by Camp Fire USA Alaska Council volunteers, employees, or agents during my child's stay at camp.

I, as the parent/legal guardian, have read this Release of Liability and Hold Harmless Agreement and understand its terms. I understand that camp may involve many risks, including, but not limited to those outlined above. I understand that this is a release of liability.

In consideration for Camp Fire USA Alaska Council's employees transporting my child to and from Soldotna and to and from activities and my child attending camp, I hereby agree to hold them their employees, volunteers, and agents harmless from any liability which may arise in connection with the transportation and supervision of my child while at camp.

The terms hereof serve as a release and assumptions of risk for me, my child, my heirs, and my estate, and for all members of our family.

THIS IS A RELEASE OF LIABILITY

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date



Alaska Council  
Outdoor Programs

Release of Liability/Hold Harmless Form

I, the parent/legal guardian of \_\_\_\_\_, understand that my child will be participating in activities that have inherent risks and may need transportation to and from camp and to and from camp activities. I understand that activities and travel may include risk of injury. I understand that these risks include, but are not limited to, death and severe bodily injury. I also understand that these risks could lead to serious impairment of my child's future ability to earn a living, engage in business, and generally enjoy life. Because of the dangers involved, I understand the importance of any and all instructions for program activities and the use of safety belts, not distracting the driver, no standing up or excessive behavior and any other driver-imposed rules, and agree to instruct my child to obey all instructions given.

In consideration for allowing the participation of my child, I hereby assume all the risks associated with program and travel and agree to hold Camp Fire USA Alaska Council and its volunteers, employees, or agents harmless from any and all liability, causes of action, deaths, claims, or demands of any nature which may arise in connection with my child's travel to, from and during camp or its activities.

In addition, it is understood that Camp Fire USA Alaska Council attempts to provide adequate supervision, but that due to the nature of camp, there may be times when my child has minimum supervision. My child has permission to engage in all camp activities except as noted by the physician or parent/guardian.

In consideration for my child being allowed to attend camp, I shall indemnify and hold harmless Camp Fire USA Alaska Council and its employees, volunteers, or agents from and against any losses, costs, damages, expenses, including attorney's fees arising out of or resulting from claims or suits, by or on the behalf of any persons, for any injury to my child, including death, or for any damages to my child's property occurring during the course of my child's participation while at camp alleged or claimed to have been caused, in whole or in part, or contributed to, by any act or omission of any of the indemnities identified herein. The terms of this agreement serve as a release.

In signing this form, I certify my understanding of this form and agree to instruct my child to abide by all of the instructions given to my child by Camp Fire USA Alaska Council volunteers, employees, or agents during my child's stay at camp.

I, as the parent/legal guardian, have read this Release of Liability and Hold Harmless Agreement and understand its terms. I understand that camp may involve many risks, including, but not limited to those outlined above. I understand that this is a release of liability.

In consideration for Camp Fire USA Alaska Council's employees transporting my child to and from Anchorage and to and from activities and my child attending camp, I hereby agree to hold them their employees, volunteers, and agents harmless from any liability which may arise in connection with the transportation and supervision of my child while at camp.

The terms hereof serve as a release and assumptions of risk for me, my child, my heirs, and my estate, and for all members of our family.

THIS IS A RELEASE OF LIABILITY

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

**Camp Fire USA Alaska Council  
Camp K on Kenai Lake**

**Release of Liability**

I understand that I and/or my child will be participating in activities that have inherent risks and will require transportation to and from Council programs and activities. I understand that activities and travel may include risk of injury. I understand that these risks include, but are not limited to, death and severe bodily injury. I also understand that these risks could lead to serious impairment of my child's future ability to earn a living, engage in business, and generally enjoy life. Because of the dangers involved, I understand the importance of any and all instructions for program activities and the use of safety belts, not distracting the driver, no standing up or excessive behavior and any other driver-imposed rules, and agree to instruct my child to obey all instructions given. In consideration for allowing the participation of my child, I hereby assume all the risks associated with program and travel and agree to hold Camp Fire USA Alaska Council and its volunteers, employees, or agents harmless from any and all liability, causes of action, deaths, claims, or demands of any nature which may arise with transportation to, from and during Council programs or its activities.

In addition, it is understood that Camp Fire USA Alaska Council attempts to provide adequate supervision, but that due to the nature of Council programs, there may be times when my child has minimum supervision. I give permission for my child to engage in all Council programs and activities except as noted by the physician or parent/guardian.

In signing this form, I certify my understanding of this form and agree to instruct my child to abide by all of the instructions given to my child by Camp Fire USA Alaska Council volunteers, employees, or agents during my child's participation in Council programs.

I, as the parent/legal guardian, have read this Release of Liability and Hold Harmless Agreement and understand its terms. I understand that Council programs may involve many risks, including, but not limited to those outlined above. I understand that this is a release of liability.

In consideration for Camp Fire USA Alaska Council's employees transporting my child to and from Anchorage and to and from off site activities. I hereby agree to hold them their employees, volunteers, and agents harmless from any liability which may arise in connection with the transportation and supervision of my child while at Council programs.

The terms hereof serve as a release and assumptions of risk for me, my child, my heirs, and my estate, and for all members of our family.

\_\_\_\_\_  
Please Print Child's Name

\_\_\_\_\_  
Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Signature of Parent/Legal Guardian if under 18 years of age

\_\_\_\_\_  
Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Signature of Adult Participant/Staff/Volunteer

**Peninsula Puffers Asthma Camp  
Code of Conduct- Signatures Required**

At camp and especially away from home, children can sometimes test the limit of appropriate behavior. The rules and expected behavior at camp are really no different than those at school.

The following are some conditions and policies:

1. The camper, parents, guardians and relatives agree to abide by the rules and regulations set by the camp for the health, safety and welfare of the campers and staff.
2. Campers are expected to use appropriate language; any foul language will result in camper going home.
3. Campers are encouraged to develop friendships with members of the opposite sex, but no display of affection is permitted.
4. Campers are to respect the rights and belongings of others.
5. All rules and policies are strictly enforced. The safety and security of our campers is of paramount importance of our staff. Therefore, any criminal act(s) or failure to abide by camp rules will result in dismissal from camp. In addition, parents, guardians, or relatives are responsible for picking up their camper in Yucaipa should it become necessary to send a camper home.

Signature of Parent/Guardian\_\_\_\_\_

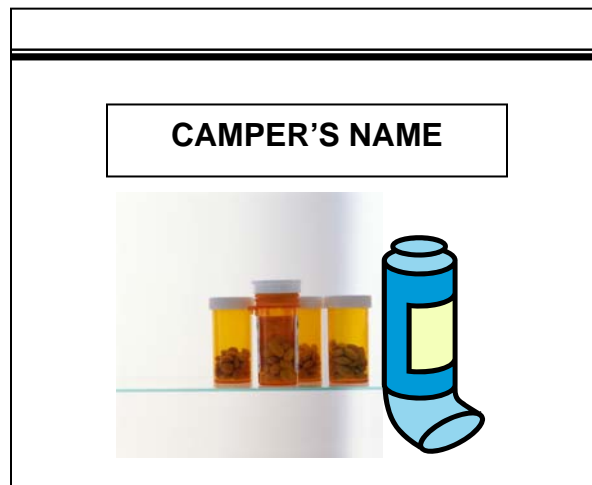
Camper's Signature \_\_\_\_\_

Date\_\_\_\_\_

# Instructions for Packing Medications for Peninsula Puffers

Note: Please bring only the COMPLETED Medication Management Plan list to the Orientation. You do NOT need to bring any medications to the meeting. Further instructions will be given at the orientation.

1. **DO NOT PACK MEDICATIONS IN THE SUITCASE.** Keep medications separate as discussed below. We will collect the medications at the bus.
2. Pack enough medications to last for a week. Put medications in a big Ziploc bag labeled with the camper's name. Bring tablets in their original bottles with the pharmacy label. **ALL CONTAINERS OF MEDICATIONS SHOULD BE LABELED WITH THE CAMPER'S NAME.**  
-unit dose containers for nebulizer meds can either be kept in their original box from the pharmacy, or placed in a separate Ziploc bag labeled with the camper's name.



3. Give your child his/her morning medicine (if needed) before going to the bus.
4. **LABEL EACH INHALER, SPACER DEVICE, PEAK FLOW METER,** with the Camper's Name. We will have Nebulizers available, so please pack the nebulizer cup and tubing labeled with the camper's name only.
5. Pack lip balm. Chapstick and insect repellent, such as Cutters or Deep Woods Off. (optional)

**Participant's Name:** \_\_\_\_\_

**Alaska Rivers Company  
PO Box 827 Cooper Landing, AK 99572**

## **WAIVER AND RELEASE AGREEMENT**

Please read carefully before signing  
This is a release of liability and waiver of certain legal rights

In consideration for my being permitted to participate in the activities of Alaska Rivers Company, I agree to the following Waiver and Release:

I acknowledge that fishing, rafting, and/or hiking have inherent risk, hazards for anyone, that cannot be eliminated, particularly in a wilderness environment. I UNDERSTAND THAT THESE RISKS, HAZARDS AND DANGERS INCLUDE WITHOUT LIMITATION:

1. Water hazards in boating and wading in the rivers including drowning;
2. Hiking in rugged country;
3. Injuries from fishing, rafting, and/or hiking equipment and other participants;
4. Encounters with wildlife, animals, and insects;
5. Extreme temperatures;
6. Inclement weather conditions and unavailability of immediate medical attention in the wilderness in case of injury.

I understand the risks, hazards, and dangers of fishing, rafting, and/or hiking and have had the opportunity to discuss them with Alaska Rivers Company. I understand that these activities may require good physical conditioning and a degree of skill and knowledge necessary for me to engage in these activities safely. I understand that I have responsibilities. My participation in this activity is purely voluntary. No one is forcing me to participate and I elect to participate in spite of the risk. I AM VOLUNTARILY USING THE SERVICES OF ALASKA RIVERS COMPANY WITH FULL KNOWLEDGE OF THE INHERENT RISKS, HAZARDS, AND DANGERS INVOLVED AND HEREBY ASSUME AND ACCEPT ANY AND ALL RISK OF INJURY, PARALYSIS, OR DEATH.

Lastly, I, for myself, my heirs, successors, executors, and subrogates, hereby ACKNOWLEDGE AND INTENTIONALLY WAIVE AND RELEASE, INDEMNIFY AND HOLD HARMLESS Alaska Rivers Company, their directors, officers, agents, employees, and volunteers from and against any and all claims, actions, causes of actions, liabilities, suits, expenses (including reasonable attorneys' fees) which are related to, arise out of, or are in any way connected with my participation in this activity including, but not limited to NEGLIGENCE of any kind or nature, whether foreseen or unforeseen, arising directly or indirectly out of any damage, loss, injury, paralysis, or death to me or my property as result of my engaging in these activities or the use of these service, animals or equipment, whether such damage, loss, injury, paralysis, or death results from negligence of Alaska Rivers Company, or from some other cause. I, for myself, my heirs, my successors, executors, and subrogates, further agree not to sue Alaska Rivers Company as a result of any injury, paralysis, or death suffered in connection with my use and participation in the activities of Alaska Rivers Company.

I HAVE CAREFULLY READ, CLEARLY UNDERSTAND, AND VOLUNTARILY SIGN  
THIS WAIVER AND RELEASE AGREEMENT.

Authorization: I hereby authorize any medical treatment deemed necessary in the event of any injury while participating in the activity. I either have appropriate insurance, or, in its absence, agree to pay all costs of rescue and/or medical services as maybe incurred on my/our behalf.

Release: In consideration of services or property provided, I, for myself and my minor children for which I am parent, legal guardian or otherwise responsible, any heirs, personal representatives or assigns, do hereby release:

Its principals, directors, officers, agents, employees and volunteers, and each and every land owner, municipal and/or governmental agency upon whose property any activity is conducted, from all liability and waive any claim for damage arising from any cause whatsoever (except that which is the result of gross negligence).

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Print: \_\_\_\_\_

# PENINSULA PUFFERS SCHOLARSHIP APPLICATION & CRITERIA

*Complete if you are requesting a Scholarship for the program. To be eligible for a scholarship, this form must be complete and faxed to 907-349-0637 by June 1, 2012. Please print clearly.*

Participant's Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_

Male  Female \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date of Birth Current Age

Parent/Guardian (if applicable): Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Relationship to Child \_\_\_\_\_

Address: Street Number \_\_\_\_\_ Apt. Number \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Alternate Phone (\_\_\_\_) \_\_\_\_\_

How much of the registration fee can you afford to pay? \_\_\_\_\_

e-mail \_\_\_\_\_

Are you currently unemployed?  Yes  No Receiving any unemployment benefits?  Yes  No

Are you currently receiving medical assistance?  Yes  No

Are you currently receiving any other form of public assistance (food stamps, etc.)?  Yes  No

Does your child use daily asthma medications?  Yes  No

How many asthma exacerbations has your child experienced in the last 4 months? \_\_\_\_\_

Does your child know their asthma triggers?  Yes  No

## BASIC SCHOLARSHIP CRITERIA

- Scholarship must be complete and received by the registration deadline.
- **Campers must submit a written letter about why they would like to attend asthma camp and what they hope to learn. Letters will weigh heavily in scholarship decisions. Camper age will be taken into consideration when reviewing letters**
- Both financial need and severity of asthma will be used to determine eligibility and amount of support. In order to support the maximum number of participant, partial scholarships may be awarded.

Parent/Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_

WHY I WANT TO ATTEND PENINSULA PUFFERS ASTHMA  
CAMP THIS SUMMER

BY \_\_\_\_\_