Peninsula Puffers
Asthma Camp 2010– **Application**

Camp is for children, ages 8 to 14, who take medications daily for their asthma.

Online Registration is available at www.aafaalaska.com

CAMP DATES: June 27 to July 2, 2010
Deadline to apply: June 15, 2010 (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.

TYPE OF FOOD/MEDICINE	REACTION (be specific)	AGE OF LAST REACTION
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

____

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:

Medication	*Dosage*	*Times taken each day*	*Reason for medication*

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 USAcollects 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)

☐ Convulsive disorders	☐ Discipline Problems	☐ Skin Disease	☐Sickle Cell Disease
☐ Orthopedic	☐ Heart Disease	☐ Bedwetting	☐ Constipation
☐ Sleep Problem	☐ Diabetes	☐ Immunodeficiency	☐ HIV Infection
☐ TB	☐ Headaches/Migraines	☐ Fainting	☐ OCD
☐ Learning Disabilities	☐ ADD	☐ Hyperactivity	☐ 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	
☐	☐	Known medical problems, besides asthma?
☐	☐	Known behavioral or psychological issues?
☐	☐	Foods that must be eliminated from this patient's camp diet?
☐	☐	Specific medication issues?
☐	☐	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
☐ STEP 4 Severe Persistent	☐ Continuous Limited physical activity. Frequent exacerbations	☐ Frequent, often 7 times/ wk	☐ FEV or PEF <60% predicted. PEF variability >30%	☐ High Dose MDI steroid, Long acting bronchodilators. Oral steroid.	☐ Beta 2 specific agonist MDI
☐ STEP 3 Moderate Persistent	☐ Daily Exacerbations affect activity. Exacerbations ≥ 2 times a week; may last days	☐ >1 time/ week, but not nightly	☐ FEV or PEF >60% to <80% predicted. PEF variability >30%	☐ Medium Dose MDI steroid, and/or long acting bronchodilators.	☐ Beta 2 specific agonist MDI
☐ STEP 2 Mild Persistent	☐ >2 times/ wk. but not daily Exacerbations may affect activity	☐ 3-4 times/ month	☐ FEV or PEF ≥80% predicted. PEF variability 20% to 30%	☐ Low Dose MDI steroid or other anti-inflammatory drugs	☐ Beta 2 specific agonist MDI
☐ STEP 1 Mild Intermittent	☐ ≤2 times/ wk. Asymptomatic & normal PEF between exacerbations. Exacerbations brief, intensity may vary.	☐ ≤ 2 times/ month	☐ FEV or PEF ≥80% predicted. PEF variability < 20%		☐ 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?