Peninsula Puffers
Asthma Camp 2023 **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 25- June 30, 2023
Deadline to apply: May 20, 2023 (Feel free to photocopy application as needed)
Please Mail Application and camp fee of $300.00 to ***OR*** ***E-mail***
Peninsula Puffers Asthma Camp aafaalaska@gci.net
C/O AAFA Alaska
P.O. Box 201927. Anchorage, AK 99520 *Fax-349-0637*

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 2023: _____ Grade in Fall '23:_____

T-shirt size (for campers) Child Size ☐L or Adult Size ☐S ☐M ☐L ☐XL

My child is current on all immunizations: ☐ Yes ☐No

My child has received the COVID-19 vaccination (check all that apply) **Initial series of vaccination is required for camp.

☐ Dose #1 ☐ Dose #2 ☐ Booster Dose for camp. Vaccine Type: (circle) Pfizer Moderna

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: **(A vaccine record should be attached to this application)**

Most recent Booster/ Tetanus/ Diptheria Shot _____/_____/_____ Chicken Pox Shot _____/_____/_____

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

All of my child's vaccinations are up to date: ☐ **Yes** ☐ **No** **** This is an ACA requirement****

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?_________

Been prescribed oral steroids 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 conditions ☐ 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
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

____

Food Allergies are managed by the following health care provider:____

Are any of the food allergens listed above tolerated when well mixed and well baked? If so please list the allergen.

____

____

____

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 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 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 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

Date of last appointment _____/_____/_____

Is patient up to date with Immunizations? ☐Yes ☐No

Please attach a copy of the campers vaccine record

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 and age at reaction
____________________	____________________
____________________	____________________

☐Yes ☐No **FOOD?**

List Food	Reaction and age at reaction	Is allergen tolerated well mixed/well baked
____________________	____________________	____________________
____________________	____________________	____________________

☐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		