Peninsula Puffers Asthma Camp 2024 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 17-21, 2024

Application Deadline: May 20, 2024 (photocopy application as needed)

Return your completed paperwork by A) *EMAIL to info@aafaalaska.com,* ***OR B)*** *FAX to 907-349-0637* ***OR***
C) POSTAL MAIL: Peninsula Puffers Asthma Camp | C/O AAFA Alaska | PO Box 201927, Anchorage, AK 99520

PART 1 (pages 1-3) to be completed by parent or guardian. PART 2 to be completed by healthcare provider (physician)

PART 1: A – CAMPBER IDENTIFICATION (please print clearly)

Camper's Full Name: _____ (Last) _____ (First) _____ (Middle)

Gender: ☐ Female ☐ Male Birthday:____/____/____ Age by August 2024: _____ Grade in Fall 2024:_____

Camper's T-shirt Size: Child/Youth Size: ☐ L OR Adult Size: ☐ S ☐ M ☐ L ☐ XL

PART 1: B – EMERGENCY CONTACT INFORMATION

Father: ☐ Primary residence

_____ Last First

_____ Address

_____ City, State Zipcode

_____ Home Phone

_____ Cell Phone

_____ Work Phone

_____ Email

Mother: ☐ Primary residence

_____ Last First

_____ Address

_____ City, State Zipcode

_____ Home Phone

_____ Cell Phone

_____ Work Phone

_____ Email

Guardian: ☐ Primary residence

_____ Last First

_____ Address

_____ City, State Zipcode

_____ Home Phone

_____ Cell Phone

_____ Work Phone

_____ Email

Other Emergency Contacts:

Name: _____ Relationship: _____ Phone: _____

Physician: _____ Phone: _____

PART 1: C – HEALTHCARE INSURANCE INFORMATION

Health Insurance Carrier: _____

Insurance Policy Number:_____ Group Number:_____

Name of Insured: _____ Relationship to Child: _____

Carrier Address: _____

PART 1: D – GENERAL HEALTH 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, depression and/or panic disorder? If yes, list medications:_____ Prescribing Physician:_____
☐	☐	Does your child have any of the following chronic conditions (if yes, check all that apply): ☐ Sickle Cell ☐ Hepatitis ☐ Diabetes ☐ Seizure Disorder ☐ Other: _____
☐	☐	Has your daughter started her menstrual cycle? If yes, list any medications she takes: _____
☐	☐	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?

_____

IMMUNIZATIONS: ☐ Attach child's immunization record

My child is current on all immunizations (**NOTE: This is an ACA requirement.): ☐ Yes ☐ No

My child received the following COVID-19 vaccinations (check all that apply; ** NOTE: Initial vaccine series is required for camp).

☐ Initial Dose #1 ☐ Initial Dose #2 ☐ Booster Dose for camp. Vaccine Type: ☐ Pfizer ☐ Moderna

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

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

MEDICATIONS:

Please list ALL medications including over-the-counter or nonprescription drugs this child takes 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
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Over-the-Counter Medications:

Camp Fire USA keeps the following over-the-counter (OTC) medications in stock to treat 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

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 ☐ 3 or more 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? (check all that apply)

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

Does your child have the following allergies or hypersensitivity? (check 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, conditions, etc., below:

Type of Food / Medicine / Condition	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(s):

_____ _____ _____

PART 1: F – PARENT 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 (i.e., website/brochures). Neither the Camp nor the Medical Staff assumes any other responsibilities.

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.

Parent/Guardian Signature: _____ **Date:** _____