Peninsula Puffers Asthma Camp 2024 Application

PART 2: This part 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: ____________________ ☐ Please attach a copy of the child's vaccine record

Does this patient have any of the following problems? (please check 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:______________

For any item checked above, please explain: ______________________________

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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?

For any item checked above checked "Yes", please explain: ______________________________

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PART 2: B – ALLERGY HISTORY

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

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

Is this patient allergic to any:

MEDICATION? ☐ Yes (list below) ☐ No

List Medications	Reaction	Age at Reaction

FOODS? ☐ Yes (list below) ☐ No

List Foods	Reaction	Age at Reaction	Is food tolerated if well mixed or baked?

OTHER? ☐ Yes (list below) ☐ No

List Other Source	Reaction	Age at Reaction

PART 2: C – ASTHMA HISTORY

Based on the NIH guidelines severity of classification, how would you rate this patient's asthma?
(please check 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/ week	☐ 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/ week 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/ week 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

Within the past year:

☐ Yes ☐ No Has this patient been to "Urgent Care" and/or ER due to asthma? If yes, how many times? ________________

☐ Yes ☐ No Have there been any hospitalizations because of asthma? If yes, how many times? ________________

☐ Yes ☐ No Has this patient required oral steroids? If yes, how many times? ________________

Oral steroid dosage: ________________ Date of most recent course: ________________

CURRENT MEDICATIONS:

DRUG	Strength	Dosage	Frequency	Syrup	Caplet	Tablet	Inhaler	Nebulizer

PART 2: D – 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