

**STAPLE  
PHOTO  
HERE**

**All Forms Due Back to ALA on June 8**



**FOR OFFICE USE ONLY**

1=Intermittent 2=Mild Persistent

3=Moderate Persistent 4=Severe Persistent

Asthma Ranking \_\_\_\_\_

Social/Emotional Ranking \_\_\_\_\_

Other Notes \_\_\_\_\_

**CAMPER HEALTH FORM**

**GENERAL INFORMATION** (to be completed by parents)

Camper Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Last First Middle Initial

Sex: Male Female Nickname \_\_\_\_\_ Age at Camp \_\_\_\_ Grade Entering in Fall \_\_\_\_

Name of the school your child will be entering in the Fall of 2012: \_\_\_\_\_

Address of school: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

**Father:**  Check if Primary Residence      **Mother:**  Check if Primary Residence      **Guardian(s):**  Check if Primary Residence

Father			Mother			Guardian(s)		
Last	First	Address	Last	First	Address	Last	First	Address
City	State	Zip	City	State	Zip	City	State	Zip
( )			( )			( )		
Home Telephone			Home Telephone			Home Telephone		
( )			( )			( )		
Work Telephone			Work Telephone			Work Telephone		
( )			( )			( )		
Cell Telephone			Cell Telephone			Cell Telephone		

What county does your camper live in? \_\_\_\_\_ What T-shirt size for camper? (**Adult sizes only**) S M L XL XXL

Who will be the primary contact while your child is at camp? \_\_\_\_\_ Best # to call? ( ) \_\_\_\_\_

Who is (are) the legal guardian(s) for this child? \_\_\_\_\_

Are there any custody or visitation restrictions? **Yes No** If yes, please describe \_\_\_\_\_

If parents/guardian are not available in an emergency, please notify (*this must be filled out*)

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**CAMPER INFORMATION: Has your child:**

Attended this camp before? **Yes No** Please circle years 2003 2004 2005 2006 2007 2008 2010 2011

Attended other asthma camps? **Yes No** Name and location \_\_\_\_\_

Attended other residential non-asthma camps? **Yes No** Name and location \_\_\_\_\_

Camped with family or others? **Yes No** Explain \_\_\_\_\_

Ever been away from home and parents for five days or more? **Yes No** Explain \_\_\_\_\_

Suffered from homesickness? **Yes No** Explain \_\_\_\_\_

Been placed on any activity restrictions? **Yes No** Explain \_\_\_\_\_

Had any recent changes in their family? **Yes No** Explain \_\_\_\_\_

Camper Name \_\_\_\_\_

## HEALTHCARE PROVIDER INFORMATION

**Please indicate all healthcare providers your child presently sees:**

Pediatrics/General \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Name

Allergist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Name

Pulmonologist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Name

Other \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Name

Do you have insurance for your child?  Yes  No

Name of Insurance Plan \_\_\_\_\_

Policy/Group # \_\_\_\_\_ Member #/ID # \_\_\_\_\_

## CAMPER HEALTH HISTORY

(to be completed by camper's parent)

### Most recent

**Immunization dates:** DT \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ MMR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Hepatitis B \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Influenza \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Does your child have any of the following health concerns?**

Heart Disease \_\_\_\_\_  Yes  No Fainting \_\_\_\_\_  Yes  No Sleepwalking \_\_\_\_\_  Yes  No

Diabetes \_\_\_\_\_  Yes  No Discipline Problems \_\_\_\_\_  Yes  No Hyperactivity \_\_\_\_\_  Yes  No

Convulsive Disorders \_\_\_\_\_  Yes  No Bedwetting \_\_\_\_\_  Yes  No Constipation \_\_\_\_\_  Yes  No

Learning Disability \_\_\_\_\_  Yes  No ADD/OCD (circle) \_\_\_\_\_  Yes  No Other \_\_\_\_\_

**If you answered yes to any of the above, please explain:** \_\_\_\_\_

**Are there any present physical education restrictions at school?**  Yes  No Explain: \_\_\_\_\_

**Are there other medical conditions, other than asthma and allergies, for which your child is being treated or followed by a health care provider?**  Yes  No

If yes, please explain: \_\_\_\_\_

**Who is responsible for giving your child asthma medication at home?**  Child  Parent  Other \_\_\_\_\_

**Does your child use a peak flow meter?**  Yes  No **If yes, what is your child's normal reading?** \_\_\_\_\_

Do they use it regularly?  Yes  No

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

**On a scale of 0 to 10, how would you rank your child's asthma? (Circle only one number!)**

(NO ASTHMA) 0    1    2    3    4    5    6    7    8    9    10 (SEVERE ASTHMA)

Camper Name \_\_\_\_\_

### ALL MEDICATIONS

Please include asthma and non-asthma medications  
(to be completed by parent/guardian)

DRUG NAME (indicate if it is an inhaler, nebulizer or pill)	STRENGTH	DOSAGE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### HISTORY OF ASTHMA

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

WITHIN THE PAST 3 MONTHS, (on the average):

How many nights per week does your child wake up because of asthma or coughing? Nights per week \_\_\_\_\_

How much does your child's asthma interfere with exercise?  None  Some  A lot

How many days per week does your child need to use their reliever (rescue inhaler)? Days per week \_\_\_\_\_

WITHIN THE PAST YEAR ONLY, how many times has your child:

Been home from school because of asthma? Number of days \_\_\_\_\_

Went to the doctor's office because of difficulty with his/her asthma? Number of times \_\_\_\_\_

Been to the emergency room or urgent care clinic because of asthma? Number of times \_\_\_\_\_

Been on oral corticosteroids (e.g., prednisone, Prelone, Prediapred) How many times? \_\_\_\_\_ Most recent date \_\_\_\_\_

WITHIN THE PAST 5 YEARS, has your child been:

Admitted to the hospital for asthma?  Yes  No How many times? \_\_\_\_\_ Age (most recent)? \_\_\_\_\_

In an intensive care unit for asthma?  Yes  No How many times? \_\_\_\_\_ Age (most recent)? \_\_\_\_\_

Intubated for asthma?  Yes  No How many times? \_\_\_\_\_ Age (most recent)? \_\_\_\_\_

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Camper  
Name \_\_\_\_\_

## ALLERGY INFORMATION

Is your child allergic to any:

**MEDICATION (penicillin, sulfa, etc.)?**  Yes  No

Medication Name	Reaction (be specific)	Age of Last Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FOODS?**  Yes  No

Food	Reaction (be specific)	Age of Last Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ANIMALS or INSECTS?**  Yes  No

Animal or Insect	Reaction (be specific)	Age of Last Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

## BEHAVIORAL HISTORY

*Our goal is to assist all campers in having a safe and positive camp experience. Personal information is as important as medical information in meeting this goal. All information will be kept confidential with your camper's healthcare team.*

Does your child have any behavioral issues at school and/or camp (if applicable) we should be aware of? \_\_\_\_\_

What methods have worked to positively redirect your child at home or school? \_\_\_\_\_

Is your child self-conscious about his/her asthma (e.g., using an inhaler in public)? \_\_\_\_\_

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

\_\_\_\_\_  
Date

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Camper  
Name \_\_\_\_\_

## PARENT'S AUTHORIZATION

***Both sides must be completed for application to be considered***

### PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in Camp SuperKids held June 24-29, 2012, sponsored by the American Lung Association in Minnesota, as parent/guardian I hereby release the Association, its Incorporators, Physicians, Board Members, Officers, Employees, Agents, Independent Contractors and Volunteer Workers from any liability for injuries which are sustained during the camp, **including any necessary transportation**. The child herein described has permission to engage in all scheduled activities except as noted by the physician or parent/guardian. I hereby give permission to the camp physician to initiate and provide any necessary treatments, including transporting to the nearest certified emergency facility. If hospitalization is required, the child is to be referred to an appropriate physician and all treatments will be at my expense.

### PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE

I do hereby acknowledge and authorize Camp SuperKids and the American Lung Association of Minnesota to take and use photographs, video and written comments of or by my child for promotional and informational materials. Further, I agree to release and discharge Camp SuperKids and the American Lung Association in Minnesota and its sponsors from any and all liability in connection with the use of such photographs, videos and written comments of or by my child.

### Release for Transport Home

At the conclusion of camp, the Camp Staff may release my child to me, or to the individual(s) designated below. Under no circumstances will your child be released to anyone not specified by you. Picture ID may be required.

I will be picking up my own child.

Alternate adult designated to pick up my child for me.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Please Print

**\*\*\*We need your signature below even if YOU are planning on picking up your child.\*\*\***

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Signature of Parent or Guardian Date

### AUTHORIZATION TO RELEASE MEDICAL DATA

I do hereby authorize Camp SuperKids and American Lung Association in Minnesota to release medical data for the purpose of compiling and assessing national asthma medical information. I understand that all data will be analyzed in aggregate form protecting the confidentiality of my child.

I authorize Camp SuperKids to provide necessary medical information about my child(s) to my child's school/school nurse.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Please Print

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
Signature of Parent or Guardian Date

### HOW DID YOU HEAR ABOUT ASTHMA CAMP?

Please circle one:

- |  |   |                                      |  |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> Healthcare Provider's Office  | <input type="checkbox"/> Social Worker      | <input type="checkbox"/> Radio       | <input type="checkbox"/> Internet/Web Site |
| <input type="checkbox"/> School Nurse                  | <input type="checkbox"/> TV                 | <input type="checkbox"/> Newspaper   | <input type="checkbox"/> Magazine          |
| <input type="checkbox"/> Friend                        | <input type="checkbox"/> Called or wrote to | <input type="checkbox"/> Other _____ |  |
| <input type="checkbox"/> Previous camper or camp staff | ALA or AAFA                                 |                                      |  |

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Camper  
Name \_\_\_\_\_

## CAMPER CODE OF CONDUCT

(Please review with your child)

It is our hope that everyone that participates in our program will have a positive experience that will last a lifetime. To help everyone get the most out of their camp experience, we have set up a list of ground rules to help parents and children understand what we expect at camp. We recognize the special needs of our campers and will as much as possible; individualize the rules according to the needs and abilities of each camper.

Camp has four basic rules that we explain to the children and also post in the cabins. We have these rules so that everyone can be assured of a positive experience.

- **Respect yourself, others and property.** This means abusiveness toward others or using inappropriate language, fighting, stealing, etc. It also covers property damage, graffiti or vandalism. Respect yourself, refers to keeping your things picked up, personal hygiene and taking your medication on time.
- **Participate in camp activities.** It is camp's responsibility to know where all the campers are at all times. We ask campers to be at all activities unless excused by staff. Campers cannot be left alone in their cabin.
- **Follow directions.** There are a lot of fun things to do at camp but every activity has rules so we can operate the activity safely and appropriately. We ask the campers to follow staff direction during these activities.
- **No put-downs.** Examples of this would include teasing, name-calling, racial slurs or inappropriate practical jokes.

If we do have a problem with inappropriate behavior, we have a camper behavior response policy. The counselor will start by giving the child a warning, and then a time-out with an explanation and discussion on what is causing the problem. If the counselor needs help, a behavioral specialist or the designated healthcare team supervisor on site will work with the child to help avoid further problems. We will also call home to find out if the parents have any suggestions on ways to deter the inappropriate behavior. As a last resort, we may need to send a child home. Sometimes in the case of severe homesickness or if misbehavior could cause immediate harm to themselves or others, we reserve the right to immediately ask that the child be removed from camp.

It is our hope that each child will go home with great memories of camp. These rules are designed to protect the camper's experience so that one unruly child won't ruin the experience for the rest. If you have any questions or comments, please feel free to call. It is our mission to provide a quality experience for everyone.

\*\*\*In the event your child needs to be escorted home due to poor behavior, you, as parent/guardian, hereby release the Association, its Incorporators, Physicians, Board Members, Officers, Employees, Agents, Independent Contractors and Volunteer Workers from any liability.

**I understand and accept that my child must abide by the Camper Code of Conduct**

\_\_\_\_\_  
Parent's Signature

**I agree to abide by the Camper Code of Conduct** \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Camper's Signature Date

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# ASTHMA CAMP MEDICAL HISTORY AND PHYSICAL EXAMINATION

(MUST be completed & signed by the child's healthcare provider)

Camper Name \_\_\_\_\_

### An important note to Healthcare Providers:

This Medical History and Physical Examination form is a **mandatory** part of your patient's asthma camp application. If applicable, please try to simplify the medication regime that the child follows during camp. For example: If a medication can be given TID, with meals, instead of QID (or BID instead of TID), this would be helpful for the child and the medical personnel. Furthermore, inhalation therapy with a nebulizer can be time consuming for the child at camp; please carefully review the child's need for this form of therapy. **\*\*\*Also, allergy shots will not be given at camp.\*\*\***

Child's name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_

Date of last physical exam \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**\*\*Last physical exam MUST take place after July 2011!**

#### Immunization Dates:

DT \_\_\_\_\_ Hepatitis B \_\_\_\_\_

MMR \_\_\_\_\_ Chicken Pox \_\_\_\_\_

## HISTORY

*Please circle Yes (Y) or No (N)*

1. Is this patient under regular care? \_\_\_\_\_ **Y / N** Date of last appointment \_\_\_\_ / \_\_\_\_ / \_\_\_\_

2. Have there been any hospitalizations for asthma in the PAST 5 YEARS? \_\_\_\_\_ **Y / N** How many? \_\_\_\_\_  
Date of most recent hospitalization (month, year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

3. Has this child been:

a. In the ICU or intubated because of asthma in the PAST 5 YEARS? **Y / N** How many times? \_\_\_\_\_  
Date of most recent ICU admittance or intubation? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

b. On oral corticosteroids within the PAST YEAR? \_\_\_\_\_ **Y / N** How many times? \_\_\_\_\_  
Date of most recent course? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

c. Hospitalized for reasons other than asthma? \_\_\_\_\_ **Y / N** How many times? \_\_\_\_\_

4. Has this child received the following tests or evaluations in the past year?

Health/Development History \_\_\_\_\_ **Y / N**

Physical Examination \_\_\_\_\_ **Y / N**

5. Does this child have any of the following problems?

Convulsive disorders _____ <b>Y / N</b>	Heart Disease _____ <b>Y / N</b>	Discipline Problems _____ <b>Y / N</b>
Hyperactivity _____ <b>Y / N</b>	Fainting _____ <b>Y / N</b>	Sleepwalking _____ <b>Y / N</b>
Diabetes _____ <b>Y / N</b>	Bedwetting _____ <b>Y / N</b>	Constipation _____ <b>Y / N</b>
Learning Disabilities _____ <b>Y / N</b>	ADD _____ <b>Y / N</b>	ODD _____ <b>Y / N</b>
OCD _____ <b>Y / N</b>	Other _____ <b>Y / N</b>	

Explain any "yes" answers \_\_\_\_\_

6. Does the Camp Healthcare team need to be aware of any of the following:

- a. Known medical problems, besides asthma? \_\_\_\_\_ **Y / N**
- b. Known behavioral or psychological issues? \_\_\_\_\_ **Y / N**
- c. Foods that must be completely eliminated from this patient's camp diet? \_\_\_\_\_ **Y / N**
- d. Other allergy or sensitivity problems? \_\_\_\_\_ **Y / N**
- e. Specific medication issues? \_\_\_\_\_ **Y / N**
- f. Treatments you prefer **not** be used at camp? \_\_\_\_\_ **Y / N**
- g. Restrictions/limitations on participation in any asthma camp activities? \_\_\_\_\_ **Y / N**

Please explain any "yes" answers (please be specific) \_\_\_\_\_

7. Based on the NHLBI's guidelines severity classification, how would you classify this child's asthma?

Intermittent Asthma      Persistent Asthma:  Mild       Moderate       Severe

8. How would you rate the severity of this child's asthma on a scale of 0 – 10? (Circle one number only)

(NO ASTHMA) 0      1      2      3      4      5      6      7      8      9      10 (SEVERE ASTHMA)

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Camper  
Name \_\_\_\_\_

**Please include asthma and non-asthma medications**

DRUG NAME (include if it is an inhaler, nebulizer or pill)	STRENGTH	DOSAGE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### ALLERGY INFORMATION

Is this child allergic to any:

**MEDICATION?**  Yes  No

Medication	Reaction (be specific)	Age of Last Reaction
------------	------------------------	----------------------

_____	_____	_____
_____	_____	_____

**FOODS?**  Yes  No

Food	Reaction (be specific)	Age of Last Reaction
------	------------------------	----------------------

_____	_____	_____
_____	_____	_____

**ANIMALS or INSECTS?**  Yes  No

Animal or Insect	Reaction (be specific)	Age of Last Reaction
------------------	------------------------	----------------------

_____	_____	_____
_____	_____	_____

### 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

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

( ) \_\_\_\_\_  
Telephone

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Date

Would you volunteer at camp?  Y  N

Please return to: Cynthia Isaacson Fax: 651-227-5459  
Mail: 490 Concordia Ave St. Paul, MN 55103

By: **June 8, 2012**