Staple or tape recent photo here

Camper Application 2017

CAMPER INFORMATION

APPLICATION INSTRUCTIONS:

1. **Complete the application and return it to the address listed below by *April 7th* (Please call the Director to verify it was received):**

   American Lung Association in Arizona
   Attn: Camp Director
   102 W. McDowell Road
   Phoenix, AZ 85003
   Fax: (877) 276-2108
   Office: (602) 258-7505

2. **Please do not leave any questions or sections blank.**

CHECK LIST:

Make sure you have enclosed the following:

- ❑ **Application filled out completely**
- ❑ **Photo of the child**
- ❑ **Copy of Health Insurance Card**
- ❑ **Copy of Immunization Records**
- ❑ **Copy of Two Most Recent Paystubs (If Applying For Campership)**
- ❑ **Deposit ($50)** - If there is an issue supplying this deposit in full please contact *Stacey Mortenson 602-258-7507*

Name of Child

_____ Date of Birth _____

Prefers To Be Called _____ Social Security Number _____

Gender ☐**Female** ☐**Male** Present Grade (Or Last Grade) _____ Age at Camp _____

What Is Your Child's Primary Language? _____ Other Languages Spoken: _____

*Ethnicity ☐Hispanic ☐Non-Hispanic

*Race ☐American Indian or Alaskan Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐White

**This information is collected only for demographic reporting to our funders and is not considered during the acceptance process.*

Has Your Child Attended This Camp Before? ☐**Yes** ☐**No** **# of Years:** ☐ **01** ☐ **02** ☐ **03**

How Did You Hear About Camp Not-A-Wheeze?
☐**Friend/Family** ☐**Doctor/Nurse** ☐**School** ☐**Other** _____

Camper's T-shirt size: **Child sizes:** ☐ S ☐ M ☐ L ☐ XL OR **Adult sizes:** ☐ S ☐ M ☐ L ☐ XL ☐XXL

CONTACT INFORMATION

Parent/Guardian 1 _____ Relationship To Child _____ Home (____)_____

Cell (____)_____ Work (____)_____ Email _____

Parent/Guardian 2 _____ Relationship To Child _____ Home (____)_____

Cell (____)_____ Work (____)_____ Email _____

Parent/Guardian 3 _____ Relationship To Child _____ Home (____)_____

Cell (____)_____ Work (____)_____ Email _____

MAILING ADDRESS (address of the parent or guardian that the child lives with)

Street _____ Apt/Unit _____

City _____ State_____ _ Zip Code _____ County _____

School Name _____

Are parents living together? ☐ **Yes** ☐ **No**

Are there any custody or visitation restrictions? If so, describe _____

_____

EMERGENCY CONTACTS (this *must* be filled out)

IF I AM NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:

I authorize the following person(s) to be contacted in an emergency, and give my permission to turn my child over to the person(s), if for any reason my child must leave camp and I cannot be reached.

Name _____ Relationship to child _____

Phone (____)_____ Cell Phone (____)_____

Name _____ Relationship to child _____

Phone (____)_____ Cell Phone (____)_____

Parent/Guardian Signature: _____ Date: _____

HEALTHCARE PROVIDER INFORMATION

Who is your child's primary health care provider?

☐ Pediatrician ☐ Family Practitioner ☐ Nurse Practitioner ☐ Don't Know

☐ Other If Other: _____

Name of child's primary healthcare provider _____ Phone (____)_____

Street Address, City, State, Zip Code _____

Does your child currently see: ☐ Allergist ☐ Pulmonologist ☐ Don't know

Name of Physician _____ Phone (____)_____

Street Address, City, State, Zip Code _____

Does your child currently see: ☐ Psychiatrist ☐ Psychologist ☐Counselor

Name of Psychiatrist _____ Phone (_____)_____

Street Address, City, State, Zip Code _____

Name of Psychologist/Counselor _____ Phone (_____)_____

Street Address, City, State, Zip Code _____

ASTHMA HISTORY

How long has your child had asthma? _____

Who is responsible for giving your child's asthma medicine at home? ☐ Child ☐Parent ☐Both

Please list your child's known asthma triggers or things that make your child's asthma worse *(examples: exercise, colds, dust, mold, pollen, animals, smoke)* _____

Does your child use a peak flow meter to monitor his/her asthma? ☐ **Yes** ☐ **No**

If yes: What is his/her usual "best" peak flow rate? _____

Child's **Height** _____ Child's **Weight** _____

Does your child have a written asthma action plan? ☐ **Yes** ☐ **No**

If yes: Please attach a copy with this application.

I. Asthma Severity (*Within Last 12 Months)*

Has your child been in an intensive care unit for asthma? ☐**Yes** ☐**No**

If yes: How many times total? _____ *Date of last episode* _____

Does your child take any of the following daily controller medicines? *Check any that they take.*

☐ Advair ☐ Symbicort ☐ Dulera ☐ Flovent ☐ Asmanex

☐ Pulmicort ☐ QVAR ☐ Alvesco ☐ Other: _____

Does your child get anti-IgE treatment (Xolair shots every few weeks) for asthma? ☐ **Yes** ☐ **No**

II. Asthma Control (*Within Last 12 Months)*

Does your child take a "quick-relief" or emergency inhaler (Albuterol, Proventil, Ventolin, ProAir, Xopenex) for asthma symptoms more than 2days a week? ☐ **Yes** ☐ **No** (**Pre-treatment before exercise does not count)**

Does your child wake at night with asthma symptoms more than 2 times a month? ☐ **Yes** ☐ **No**

Has your child missed more than 5 days of school in the **last 12 months** because of asthma? ☐ **Yes** ☐ **No**

- Has your child been taken to the Emergency Department because of asthma symptoms? ☐ **Yes** ☐ **No**
  If yes: How many times total? _____ *Date of last visit* _____
- Has your child been admitted to the hospital overnight for asthma? ☐ **Yes** ☐ **No**
  If yes: How many times total? _____ *Date of last admission*_____

- Has your child been given oral corticosteroids (like Prednisone, Prednisolone, Dexamethasone, Medrol, Deltasone, Decadron, Pediapred, Prelone, Liquipred, Oralpred) to control your child's asthma? ☐ **Yes** ☐ **No**
  If yes: How many times total? _____ *Date of last time*_____

On a scale of 0-10, how bad (severe) has your child's asthma been over the last 12 months? *Circle one number only!*
(NO ASTHMA SYMPTOMS) **0 1 2 3 4 5 6 7 8 9 10** (SEVERE ASTHMA SYMPTOMS)

Describe any emotional affects you have observed in your child due to asthma:

_____

_____

_____

_____

GENERAL MEDICAL HISTORY

Does your child have head lice? ☐ **Yes** ☐ **No**

If yes, has your child been treated for head lice? ☐ **Yes** ☐ **No**

Immunizations:

You MUST include a copy of your child's immunization record to be considered for approval.

Is your child up to date on all immunizations? ☐ **Yes** ☐ **No**

If no what is missing? _____

Allergies:

Please check if your child has problems with any of the following:

Allergies	**Reaction**	**What Makes it Better?**
Example: Melons, potatoes	*Gets rash*	*Benadryl*
❑ Animals (especially horses), Insects (bees, wasps, hornets)		
❑ Food (list specific foods to be avoided)		
❑ Medications (penicillin, sulfa, aspirin)		
❑ Airborne (mold, pollen, dust, smoke)		
❑ Other		

Medical Problems OTHER THAN Asthma:

Are there any activities your child should avoid at camp? If yes, please explain:

_____

_____

_____

Please list and describe any other medical problems your child has, or is treated for. This will help the camp staff and doctors better care for your child.

_____

_____

_____

_____

Does your child wet the bed? _____ (*They can still attend camp; however, please provide extra bedding, any mattress covers used, or Pull-ups.)*

CURRENT MEDICINES

At Camp Not-A-Wheeze, doctors are available 24 hours a day to manage your child's health. A complete list of all medicines used by your child will allow the doctors to better care for your child.

Please list all the medicines your child currently takes **EVERY DAY**, even when their asthma is under control. Also include any over-the-counter and non-asthma related medications taken regularly.

PLEASE MAKE SURE THAT THIS IS ACCURATE – WE WILL USE THIS LIST WHILE YOUR CHILD IS AT CAMP.

ASTHMA MEDICINES	HOW MUCH TO TAKE	WHEN TO TAKE	OTHER INSTRUCTIONS
OTHER MEDICINES			

OTHER MEDICINES (Cont)	HOW MUCH TO TAKE	WHEN TO TAKE	OTHER INSTRUCTIONS

HEALTH INSURANCE INFORMATION

Name and Address of Insurance Company _____

Phone Number _____ Policy Number _____ Group Number_____

If group insurance, specify company (Where Employed) _____

Name of Parent/Guardian who insures child _____

Address of Parent/Guardian who insures child (If not same as the mailing address):

Street Address, City, State, Zip Code _____

Employment status: ☐Full Time ☐Part Time ☐Unemployed ☐Student ☐Retired ☐ Other _____

Social security number of policy holder: _____

Please attach a copy of the front and back of your child's medical insurance card with this application.

Camperships

Camperships *(financial assistance) are available based on the financial needs of the family. Full and partial campership amounts will be awarded based on the financial needs of each individual family and based on the federal poverty guidelines.. The system of determining need considers income standards and family medical expenses. It is not the intent of the* ***American Lung Association in Arizona*** *to turn away any child from camp due to their financial situation, but rather to allocate our limited resources so that as many requests as possible can be met. Every effort is made to see that all eligible children attend camp.* ***Please Attach Your Two Most Recent Paystubs to This Application!***

a. Number of Family Members in Household Currently _____

b. Gross Monthly Household Earned Income: $_____

c. Are You Currently Receiving Child Support?

☐Yes ☐No If Yes, Amount $_____

d. Are You Currently Receiving Alimony?

☐Yes ☐No If Yes, Amount $_____

e. Total Family Monthly Income (Gross) $_____ (Add lines **b**, **c** and **d**)
(Including All of the Above)

f. Total Monthly Household Unearned Income
(Food stamps, Disability, Housing Assistance, Etc.) $_____

g. Total Average Monthly Expenses $_____
(Including Rent, Utilities, Food, Etc.)

h. Average Monthly Medical Expenses $_____

Please Explain Any Extenuating Circumstances:

_____

_____

I Certify That The Above Information Is Correct And Accurate To The Best Of My Knowledge.

_____ _____

Signature *Date*