AMERICAN LUNG ASSOCIATION® IN UTAH

Please return to:
American Lung Association in Utah
c/o Jamie Riccobono
1930 South 1100 East
Salt Lake City, UT 84106

DUE by June 26, 2015

2015 HEALTH FORM

Note: Many items may seem irrelevant, but are actually used for grant reports and requests for funding. Please fill out the health form in its entirety.

GENERAL INFORMATION - to be completed by parents

NAME OF CHILD _____

PREFERS TO BE CALLED _____

Birthday _____ Sex: Female____ Male_____ Age At Camp____ Present grade (recent past grade) ____

Name(s) of Parents (or Guardians)

Father _____ Phone: Home (___) _____ Work (___)_____ Cell (___) _____

Email _____

Mother _____ Phone: Home (___)_____ Work (___)_____ Cell (___) _____

Email _____

Or Guardians _____ Phone Home (___)_____ Work (___)_____ Cell (___)_____

Email _____

MAILING ADDRESS _____ City_____ State_____ Zip Code _____

Are parents living together? ___ Yes ___ No

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

_____

IF NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY: (this must be filled out)

Name _____ Relationship to child _____ Phone(___)_____

Name _____ Relationship to child _____ Phone(___)_____

Who is your child's primary care MD?

___Pediatrician ___Family Practitioner ___Don't Know ___Other

If other:_____

Name of child's regular physician _____ Phone (___)_____ Address _____

Does your child currently see an asthma specialist? ___Yes ___No
If so, which type? ____Allergist ____Pulmonologist ____Don't Know

Name of child's asthma physician _____ Phone (___)_____

Address _____

What does your child have for medical insurance?

___PPO ___HMO ___Medic-Aid ___CHIP ___None ___Don't Know

Name of Health Insurance Plan _________________________________

Policy or Group Number _________________________________

Has your child attended this Camp before**?** ____Yes ____No

If so, for how many sessions**?** ____sessions

Has your child ever been to an overnight camp? ____Yes ____No

Collected for grant purposes: Family size __________ Family income __________

MEDICATIONS - *to be completed by parent and preferably verified by physician*

1. My child takes the following ASTHMA medications:

Medication	Strength	Amount (puffs, tabs, caps, ampules, tsp, cc)	Regular or as needed?	How often?				Specific Instructions
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	

Additional Specific Instructions:

____

____

____

Is your child on allergy injections? ____Yes ____No

****NOTE:** No allergy shots will be given at camp (unless there are special circumstances).

Does your child use a spacer or assisting device with his/her inhaler? ____Yes ____No

Is there any medication treatment you prefer not be used at camp for you child? ________________________________

Does your child have a specific Asthma Action Plan? ____Yes ____No

If so, please attach to this form.

HISTORY OF ASTHMA - *to be completed by parent and preferably verified by physician*

1) How long has your child had asthma? ____years

2) Within the past 5 years:

A) Has your child been admitted to the hospital for asthma? ____Yes ____No How many times total? ____

How old was he or she each time? ____

B) Has your child been in an intensive care unit for asthma? ____Yes ____No How many times total? ____

How old was he or she each time? ____________

3) Within the past three months (on average):

A) How many nights per week, does your child wake up because of asthma or coughing? ____nights per week

B) How much does your child's asthma interfere with exercise?

____None ____Some ____Moderate ____A lot

4) Within this past year only, how many times did your child need to: (list number of times)

A) Stay home from school because of asthma? ____days

B) Be taken to the doctor's office because of difficulty with his or her asthma (not including routine office visits)? ____times

C) Be taken to the emergency room or urgent care clinic because of asthma difficulty? ____times

D) Be admitted to the hospital for asthma? ____Yes ____No How many times total? ____ How old was he or she each time? ____

E) Be in an intensive care unit for asthma? ____Yes ____No How many times total? ____ How old was he or she each time? ____

5) How many times (in the past year only) have oral corticosterioids been used for the control of your child's asthma?
(Note: Oral corticosteroids are medications taken by mouth in either pill or liquid form, and are usually used when other medications cannot adequately control asthma symptoms. Names of oral corticosteroids include: PILLS: Prednisone, Medrol, Deltasone, Decadron and others LIQUIDS: Pediapred, Prelone, Liquidpred, OraPred, BubblyPred and others.)

_____courses of oral corticosteroids have been taken in the past year. Date of most recent course? _____

6) Who is responsible for giving your child's asthma medication at home?

____Child ____Parent ____Both

7) Does your child use a peak flow meter? ____Yes ____No

If yes, what is your child's normal reading? _____

Does your child use it routinely? ____Yes ____No

If so, how often? ____time(s) a day ____time(s) a week

8) On a scale of 0-10, how bad (severe) has your child's asthma been over the last year? (CIRCLE ONE NUMBER ONLY!)

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

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

_____

_____

_____

HISTORY OF ALLERGIES - *to be completed by parent and preferable verified by physician*

Is our child allergic to any MEDICATION? (Penicillin, sulfa, etc.)? ____Yes ____No If yes, please list:

Medication Name	Reactions* (be specific with the symptoms, how severe, when they start, etc.)	Age of Last Reaction

Is our child allergic to any FOODS? ____Yes ____No If yes, please list:

Food Name	Reactions* (be specific with the symptoms, how severe, when they start, etc.)	Age of Last Reaction

Is our child allergic to any ANIMALS? ____Yes ____No

If yes, please list:

Animal	Reactions* (be specific with the symptoms, how severe, when they start, etc.)	Age of Last Reaction

Is our child allergic to any INSECTS? ____Yes ____No

If yes, please list:

Insect	Reactions* (be specific with the symptoms, how severe, when they start, etc.)	Age of Last Reaction

**Reactions include: Severe total body reaction (anaphylaxis); shock; skin problems (hives, redness, blistering, itchy skin, swelling); breathing problems (wheeze, cough, chest tightness); mouth problems (swollen lips, rash, tongue swelling, itchy); throat problems (swollen, itchy, scratchy); eye problems (swollen, itchy, watery); nose problems (itchy, runny, stuffy, sneezing); intestinal problems (abdominal pain, vomiting, diarrhea); behavior/sleep problems (stimulation, hyper, strange behavior, sleepiness, trouble sleeping)*

Was emergency treatment needed for any of the reactions listed above (e.g. 911, ER visit, Urgent Care, EpiPen?)? ____Yes ____No
If so, explain:

_____
_____

OTHER INFORMATION - *to be completed by parent*

Has your child had the following illnesses?

Measles?	____Yes ____No	Rubella?	____Yes ____No
Chicken Pox?	____Yes ____No	Mumps?	____Yes ____No

Date of most recent tetanus booster: _____

DPT, Polio and MMR immunizations up-to-date? ____Yes ____No

Specifically, does your child have any of the following problems?

Convulsive Disorders?	____Yes ____No	Hyperactivity?	____Yes ____No
Diabetes?	____Yes ____No	Heart Disease?	____Yes ____No
Fainting?	____Yes ____No	Bedwetting?	____Yes ____No
Discipline Problems?	____Yes ____No	Sleepwalking?	____Yes ____No
Constipation?	____Yes ____No	Learning Disability?	____Yes ____No
Depression?	____Yes ____No	Obsessive Compulsive Disorder?	____Yes ____No
Attention Deficit Disorder?	____Yes ____No		

Are there any other medical problems or conditions your child has that the camp should know about? ____Yes ____No
If yes to any of the above questions, explain here:

_____
_____

Has your child ever camped out with the family? ____Yes ____No
If yes, were there any problems? ____Yes ____No
If yes, explain:
_____
_____

Has your child ever been away from home and parents for more than a few days? ____Yes ____No
If so, were there any problems? _____
Do you anticipate any problems with homesickness at asthma camp? _____
Does your child feel embarrassed at school or in public if he/she has to take an inhaler or nebulizer treatment? ____Yes ____No
Do you anticipate any activity restrictions? ____Yes ____No
If so, explain: _____
Are there any present physical education restrictions at school? ____Yes ____No
If so, explain: _____
Is there anything else you feel camp staff should know about your child? ____Yes ____No
If so, explain:
_____
_____

HOW DID YOU HEAR ABOUT ASTHMA CAMP?

Please check one:

___ Healthcare Provider's Office ___ Radio ___ Internet/Web Site ___ Previous camper or camp staff
___ School Nurse ___ Newspaper ___ Magazine ___ Open Airways
___ Friend ___ ALAU ___ Other _____

How often over the past 4 weeks has/have:	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
Your child complained of being short of breath					
Exertion (such as running) made your child breathless					
Your child coughed at night					
Your child been woken up by wheezing and coughing					
Your child stayed indoors because of wheezing or coughing					
Your child's education suffered due to his/her asthma (during school)					
Your child's asthma interfered with his/her life					
Asthma limited your child's activities					
You had to make adjustments to family life because of your child's asthma					

PARENT'S AUTHORIZATION

PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in Camp Wyatt, held, July 13-17, 2015, and sponsored by the American Lung Association in Utah, 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.

_____ _____

Parent signature Date

PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE

I do hereby acknowledge and authorize Camp Wyatt and the American Lung Association in Utah 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 the American Lung Association in Utah 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.

_____ _____

Parent signature Date

RELEASE FOR TRANSPORT HOME

At the conclusion of camp, the Camp Staff may release my child to myself or to the individual(s) designated below.

Name _____ Relationship to child _____ Phone ( ) _____

Please Print

_____ ___/___/___ Work Phone ( ) _____

Signature of Parent or Guardian Date

AUTHORIZATION TO RELEASE MEDICAL DATA

I do hereby authorize Camp Wyatt and the American Lung Association in Utah 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.

Name _____ Relationship to child _____ Phone ( ) _____

Please Print

_____ ___/___/___ Work Phone ( ) _____

Signature of Parent or Guardian Date

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.

Camp has four basic rules that we explain to the children. 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, then a time-out with an explanation and discussion on what is causing the problem. 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. It is our mission to provide a quality experience for everyone.

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

ASTHMA CAMP MEDICAL HISTORY AND PHYSICAL EXAMINATION - to be completed by physician

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 ___/___/___

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	Y / N	Heart Disease	Y / N	Discipline Problems	Y / N
Hyperactivity	Y / N	Fainting	Y / N	Sleepwalking	Y / N
Diabetes	Y / N	Bedwetting	Y / N	Constipation	Y / N
Learning Disabilities	Y / N	ADD	Y / N	ODD	Y / N
OCD	Y / N	Other	Y / N	Depression	Y / N

   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. Treatments you prefer **not** be used at camp? **Y / N**
   e. 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)
9. How would you rate the child's level of asthma control?
   ☐ Well controlled ☐ Not well controlled ☐ Very poorly controlled

MEDICATIONS

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 PROVDER'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

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