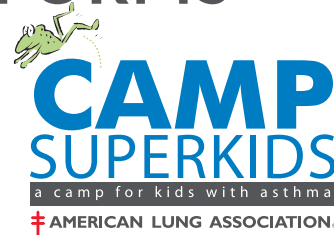


# 2019 CAMPER HEALTH FORMS

Return All Forms to Secure Spot in Camp



**Parent/Guardian**  
STAPLE PHOTO  
OF YOUR  
SON/DAUGHTER  
HERE

Parent/Guardian fills out pages 1-6  
Physician fills out pages 7-8

Camper Name \_\_\_\_\_ Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Sex  Male  Female Nickname \_\_\_\_\_ Age at Camp \_\_\_\_\_ Grade Entering in Fall \_\_\_\_\_  
First Middle Initial Last

Ethnicity  American Indian  Asian  Black or African American  Caucasian  Hispanic or Latino  Pacific Islander

Name of the school your child be entering in the Fall of 2019 \_\_\_\_\_

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

## EMERGENCY CONTACT INFORMATION

Mother:  Check if Primary Residence

First \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Father:  Check if Primary Residence

First \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

Guardian(s):  Check if Primary Residence

First \_\_\_\_\_ Last \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Telephone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Email \_\_\_\_\_

What county does your camper live in? \_\_\_\_\_ T-shirt size for camper?  YM  YL  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: 2011 2012 2013 2014 2015 2016 2017 2018

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 \_\_\_\_\_

**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 \_\_\_\_\_  
Member ID# will be used for PrimeWest members for camperships

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

- |                      |  |                           |  |               |  |
|----------------------|--|---------------------------|--|---------------|--|
| Heart Disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleepwalking  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Discipline Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hyperactivity | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsive Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bedwetting                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Constipation  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Learning Disability  | <input type="checkbox"/> Yes <input type="checkbox"/> No | ADD/OCD ( <i>circle</i> ) | <input type="checkbox"/> Yes <input type="checkbox"/> 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 (2-7 times/week)?  Yes  No

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

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**



**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 we should be aware of? *(if applicable)* \_\_\_\_\_

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 AUTHORIZATION**

**PARTICIPATION AND EMERGENCY TREATMENT WAIVER**

In consideration for being allowed to register and participate in Camp Superkids, sponsored by the American Lung Association, 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/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE**

I do hereby acknowledge and authorize Camp Superkids and the American Lung Association to take and use photographs, video and written comments of or by my child for promotional, online, and informational materials. Further, I agree to release and discharge Camp Superkids and the American Lung Association 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/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**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 will be required to pick up your camper(s).**

- 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.\*\*\***

\_\_\_\_\_  
Signature of Parent or Guardian                      Date                      Daytime Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL DATA**

I do hereby authorize Camp Superkids and American Lung Association 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 to my child's school/school nurse.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Please print

\_\_\_\_\_  
Signature of Parent or Guardian                      Date                      Daytime Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**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/Website |
| <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 the Lung Association | <input type="checkbox"/> Other _____ |   |
| <input type="checkbox"/> Previous camper or camp staff |  |                                      |   |

**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.

1. **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.
2. **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.
3. **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.
4. **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.

Signature of Parent or Guardian \_\_\_\_\_

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

**SCHEDULING YOUR CHILD'S PHYSICAL EXAMINATION**

The next two pages need to be filled out by your child's pediatrician/family practice or asthma doctor. Please schedule your appointment and indicate below when you have your appointment scheduled and return pages 1-6 to Val Haga to secure your spot in camp. Val must receive your Asthma History and Physical Examination within three days after your doctor's appointment or you may lose your place in camp.

Doctor's appointment is scheduled for: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Your doctor's office can fax Val Haga the forms (pages 7-8) to 651-227-5459.

**Please return to Val Haga**

Fax: 651-227-5459 | Mail: 490 Concordia Ave, St. Paul, MN 55103 | Email: Val.Haga@Lung.org

## ASTHMA MEDICAL HISTORY AND PHYSICAL EXAMINATION FORM

**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. **\*Allergy shots will not be given at camp.**

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

Date of last physical exam or asthma appointment \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*Last physical exam MUST take place after July 1, 2018.

### Immunization Dates

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

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

Influenza \_\_\_\_\_

## HISTORY

1. Is this patient under regular care?  Yes  No Date of last appointment \_\_\_\_ / \_\_\_\_ / \_\_\_\_

2. Have there been any hospitalizations for asthma in the PAST 5 YEARS?  Yes  No 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?  Yes  No How many times? \_\_\_\_\_

Date of most recent ICU admittance or intubation? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

b. On oral corticosteroids within the PAST YEAR?  Yes  No How many times? \_\_\_\_\_

Date of most recent course \_\_\_\_ / \_\_\_\_ / \_\_\_\_

c. Hospitalized for reasons other than asthma?  Yes  No How many times? \_\_\_\_\_

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

Health/Development History  Yes  No

Physical Examination  Yes  No

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

Convulsive disorders  Yes  No Heart Disease  Yes  No Discipline Problems  Yes  No

Hyperactivity  Yes  No Fainting  Yes  No Sleepwalking  Yes  No

Diabetes  Yes  No Bedwetting  Yes  No Constipation  Yes  No

Learning Disabilities  Yes  No ADD  Yes  No ODD  Yes  No

OCD  Yes  No Other \_\_\_\_\_

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?  Yes  No

b. Known behavioral or psychological issues?  Yes  No

c. Foods that must be completely eliminated from this patient's camp diet?  Yes  No

d. Other allergy or sensitivity problems?  Yes  No

e. Specific medication issues?  Yes  No

f. Treatments you prefer not be used at camp?  Yes  No

g. Restrictions/limitations on participation in any asthma camp activities?  Yes  No

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

Please include asthma and non-asthma medications.

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

**ALLERGY INFORMATION** Is this 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
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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	( )		
Street Address	City	State	Zip Code
Date	Would you volunteer at camp? <input type="checkbox"/> Yes <input type="checkbox"/> No		





## PAYMENT FORM

Camper's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Male  Female Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age at Camp \_\_\_\_ Attended Camp Before?  Yes  No Year(s) \_\_\_\_

Does your child take daily medication for his/her asthma  Yes  No

Parent/Guardian: First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Primary Phone \_\_\_\_\_

Address \_\_\_\_\_ Apt. Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### PAYMENT OPTIONS:

**Health Plan Coverage Numbers will be run in June; must be an active member**

• UCare Member ID # \_\_\_\_\_

• PrimeWest Health Member ID # \_\_\_\_\_

**Need-based Financial Campership**

- Send in a letter showing free or reduced school meals, or 2018 1040/1040EZ tax form
- Include a check or credit card payment according to cost on guideline table below

**Installment Plan** (\$250 now and \$245 by June 1, 2019)

- Enclose a check, or
- Pay by credit card below

**Payment in Full** (\$495)

- Enclose a check, or fill out credit card information below:

Card # \_\_\_\_\_

Exp. Date \_\_\_\_\_ CVV \_\_\_\_\_

Cardholder's Signature \_\_\_\_\_

### Need-Based Campership Guidelines

**Full Campership:** If your child receives free lunch or is less than 133% of the poverty line shown on your 1040/1040EZ taxes form

**Pay \$50:** If your child receives reduced lunch or is 150% of poverty line

**Pay \$100:** If your child is 200% of poverty line

**Pay \$200:** If your child is 250% of the poverty line

### 2018 Federal Poverty Guidelines

Family Size	100%	138%	150%	200%	250%	300%	400%
1	\$12,140	16,753	18,210	24,280	30,350	36,420	48,560
2	\$16,460	22,715	24,690	32,920	41,150	49,380	65,840
3	\$20,780	28,676	31,170	41,560	51,950	62,340	83,120
4	\$25,100	34,638	37,650	50,200	62,750	75,300	100,400
5	\$29,420	40,600	44,130	58,840	73,550	88,260	117,680
6	\$33,740	46,561	50,610	67,480	84,350	101,220	134,960
7	\$38,060	52,523	57,090	76,120	95,150	114,180	152,240
8	\$42,380	58,484	63,570	84,760	105,950	127,140	169,520
9	\$46,700	64,446	70,050	93,400	116,750	140,100	186,800

<https://familiesusa.org/product/federal-poverty-guidelines>

Turn in pages 1-9 to complete your child's registration. Acceptance letters will be sent by May 15<sup>th</sup> confirming your camper's spot and campership (if applicable). If you send in your application after May 15<sup>th</sup>, you will receive a confirmation letter within a week.

Priority will be given to first-time campers, children on daily asthma medication, and based on the number of camperships available.