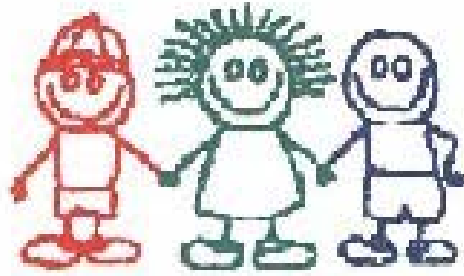


STAPLE PHOTO HERE



**FOR OFFICE USE ONLY**

Scale: 1=Mild 2=Moderate 3=Severe

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

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

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

Date Rec'd \_\_\_\_\_

**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 \_\_\_\_

**EMERGENCY CONTACT INFORMATION**

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

Last First Last First Last First

Address Address Address

City State Zip City State Zip City State Zip

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

Home Telephone Home Telephone Home Telephone

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

Work Telephone Work Telephone Work Telephone

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 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 98 99 00 01 02 03 04

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 \_\_\_\_\_

Can your child swim? **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 # \_\_\_\_\_

## CAMPER HEALTH HISTORY

(to be completed by camper's parent)

### Most recent

**immunization dates:** DT \_\_\_\_/\_\_\_\_/\_\_\_\_ MMR \_\_\_\_/\_\_\_\_/\_\_\_\_ Hepatitis B \_\_\_\_/\_\_\_\_/\_\_\_\_ Chicken Pox \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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?** \_\_\_\_\_

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

**What brand of peak flow meter?** \_\_\_\_\_ **Do they use it regularly?**  Yes  No

**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)

## 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, Pediapred) 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)? \_\_\_\_\_

## 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)? \_\_\_\_\_

## CAMPER'S COMMITMENT

I want to help make camp a fun experience. I agree to follow camp rules. I will do my best to make this a good experience for my fellow campers and myself. I understand that if I do not live up to this promise, I may be sent home from camp (without a refund).

\_\_\_\_\_  
Camper's Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# PARENT'S AUTHORIZATION

Date Rec'd \_\_\_\_\_

***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 Wonder Kids, held June 11-15 2007, sponsored by Multiple Community Resources, 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 Wonderkids and Supporting Community Resources 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 Wonderkids 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 myself 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.

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Please Print  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent or Guardian Date Work Phone (\_\_\_\_) \_\_\_\_\_

## AUTHORIZATION TO RELEASE MEDICAL DATA

I do hereby authorize Camp WonderKids 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  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Parent or Guardian Date Work 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/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                                 |                                      |  |

# 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, 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.

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 the child's healthcare provider)

Date Rec'd \_\_\_\_\_

**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 _____ <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)





# Camp WonderKids

750 North Laffoon Street  
Madisonville, KY 42431  
Phone (270) 824-1748 Fax (270) 824-1879  
e-mail tina.siddon@kctcs.edu



A Camp for Children with Asthma

## CAMP T-SHIRT

NAME \_\_\_\_\_

Please CIRCLE your t- shirt size and return this sheet with your application.

Youth Sizes

Small/Medium/Large

Adult Sizes

Medium

Large

X-Large

XX- Large

XXX- Large

