

PART 1: D- GENERAL INFORMATION

YES NO

- Has your child attended AAFA's asthma camp? If yes, please list years: _____
- Does your child get homesick/ have nightmares/ bed wets? If yes, explain _____
- Has your child been diagnosed with ADD/ ADHD/ OCD/ being hyperactive? If yes, list medications: _____
- Does your child have any of the following chronic conditions: If yes, please all that apply
 Sickle Cell Hepatitis Diabetes Seizure Disorder Other _____
- Has your daughter started her menstrual cycle? If yes, does she take medications, list medications: _____
- Has your child had any recent changes in the family? (divorce, death of family or friend)
If yes, explain: _____

What additional information should your child's cabin counselor know that will make your child's adjustment smoother at camp?

IMMUNIZATION: (You must complete all dates to apply to camp)

Most recent Booster/ Tetanus/ Diphtheria Shot ____/____/____ Chicken Pox Shot ____/____/____

If not vaccinated for chicken pox, has your child ever had chicken pox? Yes No

PART 1: E- ASTHMA/ ALLERGY INFORMATION

How long has your child had asthma? _____ years

How often does your child used Albuterol to relieve asthma symptoms?

- Once daily Less than 2 times/week More than 3 times/week

Within the past 12 months, has your child been:

Admitted to the hospital for asthma Yes No How many times? _____

To the ER or "Urgent Care" center for asthma Yes No How many times? _____

Does your child record peak flow rate? Yes No What is usual rate? _____

Has your child been instructed to adjust medicines according to peak flow rates and "symptoms" rate? Yes No

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

Does your child know how to use the following items properly? (please all that apply)

- Meter dose inhaler Spacer Peak Flow Meter Nebulizer Does not use inhaler medications

Does your child have the following allergies/hypersensitivity? (please all that apply)

- Food Medicine Cold Fog
 Dampness Altitude Skin contactants Inhalants (i.e. dust, pollens, danders)

If any of the above items were checked, please list type(s) of food, medicine, etc.

<u>TYPE OF FOOD/MEDICINE</u>	<u>REACTION (be specific)</u>	<u>AGE OF LAST REACTION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PARENT'S AUTHORIZATION

I consent to my child being photographed, videotaped or interviewed for the purpose of recording the camp experience and understand that this may be used for publicity, fundraising, or other purposes (ie. AAFA website/brochures). Neither the Camp nor the Medical Staff assumes any other responsibilities.

CONSENT FOR MEDICAL TREATMENT: I hereby give my consent for the administration and treatment that are deemed medically necessary for my child by the physicians selected by the Camp Director. I give my consent for nurses/respiratory therapists to give over the counter medication as needed.

HARMLESS CLAUSE: I further agree to release the California Chapter of Asthma & Allergy Foundation of America (AAFA) and all their agents, employees and representatives and any other individual or entity associated with AAFA, from any and all liability in the event of accident or injury to the camper, including any necessary transportation.

Signature of Parent or Guardian _____ Date _____

PART 2: Must be completed by the child's healthcare provider (physician)

Child's Name: _____
 Date of last physical exam: ____/____/____ Height:____ Weight:____ Blood Pressure:____
 Were there any abnormal findings? Yes No If yes, please explain:_____

PART 2: A- GENERAL MEDICAL HISTORY

Is this patient under your regular care? Yes No **Is patient up to date with Immunizations?** Yes No
 Date of last appointment ____/____/____

Does this patient have any of the following problems? (please all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Convulsive disorders | <input type="checkbox"/> Discipline Problems | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Orthopedic | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Sleep Problem | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immunodeficiency | <input type="checkbox"/> HIV Infection |
| <input type="checkbox"/> TB | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Fainting | <input type="checkbox"/> OCD |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> ADD | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Other |

If any of the above has been checked, please explain: _____

Contraindication to use of steroids or other medication:_____

Does the Camp Medical Staff need to be aware of any of the following?

YES NO

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Known medical problems, besides asthma? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Known behavioral or psychological issues? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Foods that must be eliminated from this patient's camp diet? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Specific medication issues? |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Restrictions/limitations on participation any asthma camp activities? |

If any of the above has been checked "YES", please explain: _____

PART 2: B- ALLERGY HISTORY

What significant allergic conditions(s) does this patient have? (please all that apply)

- Allergic Rhinitis Atopic Dermatitis Chronic/Recurrent Sinusitis Anaphylaxis Allergic GI disturbance

Is this patient allergic to any:

Yes No **MEDICATION?**

List Medications	Reaction	Age of Reaction
_____	_____	_____
_____	_____	_____

Yes No **FOOD?**

List Food	Reaction	Age of Reaction
_____	_____	_____
_____	_____	_____

Yes No **OTHERS** (i.e. bees, wasps, stings, dust mites, molds, pollens, animals)?

List Other Source	Reaction	Age of Reaction
_____	_____	_____
_____	_____	_____

PART 2: C- ASTHMA HISTORY

Based on NIH's guidelines severity of classification, how would you rate this patient's asthma?

(please one cell in each column that best describes this patient)

	CLASSIFY SEVERITY Clinical Features Before Treatment			TREATMENT	
	Symptoms	Night time Symptoms	Lung Function	Long Term	Quick Relief
<input type="checkbox"/> STEP 4 Severe Persistent	<input type="checkbox"/> Continuous Limited physical activity. Frequent exacerbations	<input type="checkbox"/> Frequent, often 7 times/ wk	<input type="checkbox"/> FEV or PEF <60% predicted. PEF variability >30%	<input type="checkbox"/> High Dose MDI steroid, Long acting bronchodilators. Oral steroid.	<input type="checkbox"/> Beta 2 specific agonist MDI
<input type="checkbox"/> STEP 3 Moderate Persistent	<input type="checkbox"/> Daily Exacerbations affect activity. Exacerbations ≥ 2 times a week; may last days	<input type="checkbox"/> >1 time/ week, but not nightly	<input type="checkbox"/> FEV or PEF >60% to <80% predicted. PEF variability >30%	<input type="checkbox"/> Medium Dose MDI steroid, and/or long acting bronchodilators.	<input type="checkbox"/> Beta 2 specific agonist MDI
<input type="checkbox"/> STEP 2 Mild Persistent	<input type="checkbox"/> >2 times/ wk. but not daily Exacerbations may affect activity	<input type="checkbox"/> 3-4 times/ month	<input type="checkbox"/> FEV or PEF ≥80% predicted. PEF variability 20% to 30%	<input type="checkbox"/> Low Dose MDI steroid or other anti-inflammatory drugs	<input type="checkbox"/> Beta 2 specific agonist MDI
<input type="checkbox"/> STEP 1 Mild Intermittent	<input type="checkbox"/> ≤2 times/ wk. Asymptomatic & normal PEF between exacerbations. Exacerbations brief, intensity may vary.	<input type="checkbox"/> ≤ 2 times/ month	<input type="checkbox"/> FEV or PEF ≥80% predicted. PEF variability < 20%		<input type="checkbox"/> Beta 2 specific agonist MDI

- YES NO In the past year, has this patient been to "Urgent Care" and/or ER due to asthma?
If yes, how many times? _____
- YES NO In the past year, have there been any hospitalizations because of asthma?
If yes, how many times? _____
- YES NO In the past year, has this patient required oral steroids? Dosage _____
If yes, how many times? _____ Date of most recent course ____/____/____

Current Medications:

DRUG	Strength	Dosage	Frequency	Syrup	Caplet	Tablet	Inhaler	Nebulizer
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____

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 Date

Clinic or Office Address Medical License # Telephone

City/State/Zip Code

- YES NO Would you like more information about the Asthma & Allergy Foundation of America (AAFA)?
 YES NO Are you interested in volunteering for AAFA's Asthma Camp?