

Illinois

55 S. Wacker, Suite 800
Chicago, IL 60601
312-781-1100
312-781-9250 fax

3000 Kelly Lane
Springfield, IL 62711
217-787-5864
217-787-5916 fax

1-800-LUNG-USA (800-586-4872)

www.lungil.org

Fighting for Air

The mission of the American Lung Association is to prevent lung disease and promote lung health.

Equal Opportunity Employer



Dear Parent/Guardian:

Thank you for inquiring about Asthma Adventure Camp. **We are hosting our 33rd camp this year from July 4-9, 2010.** Enclosed you will find a camper application. **The form needs to be completed by parent, child and physician.** Once the application is completed, please return form to:

American Lung Association in Illinois
Attn: Asthma Adventure Camp
3000 Kelly Lane
Springfield, IL 62711
or
New Option – scan and email to lkilmer@lungil.org

The entire application must be completed and returned before acceptance is considered. Do not send in the application until you have both parts completed (including physicians signature and immunization records completed or attached). Our camp filled up quickly this past year, please complete as soon as possible.

Once the application is reviewed and it is determined that all requirements are met, you will be notified by our camp director of your child's acceptance within three weeks after we receive the application. **Please note, children will be accepted based on our updated criteria:**

- Child must be between the **ages of 7 – 14** (on or before July 1, 2010)
- Child must be diagnosed with asthma and on daily medication.
- Child must be capable of walking. Our camp covers a large area and campers do a great deal of walking and hiking every day.
- **Child is required to have received the H1N1 flu vaccination.**
 - We will not be accepting “siblings” unless they are diagnosed with asthma.
 - Campers can only attend up to three years.

Asthma Adventure Camp is located at Camp Duncan, a locally owned YMCA camp site. Camp Duncan is located in Lake County near Fox Lake. An orientation packet will be sent to all families by June 15th. This packet will detail the specifics of camp, activities, what to bring, menu, directions, etc.

We are aware of the financial burden a disease can place on a family. To ease this burden, each camper pays a registration fee of \$200. No one is turned away from camp due to inability to pay. Full and partial financial scholarships are available. Please send verification of reduced school meal program if you wish to be considered for financial assistance along with your application. Please note, each family is required to send a \$25 deposit fee with their application. If you receive a full scholarship, the funds will be returned following your child's participation at Asthma Camp. If you do not request a scholarship, the deposit fee will be counted towards your registration fee.

We look forward to having your child participate in our camp program. If you have questions, please do not hesitate to call Linda and Lori at 1/800-788-5864 (lyounger@lungil.org) or (lkilmer@lungil.org).

Sincerely,

Jenn Watts, RRT
Camp Director

Lori Younker
Program Director



ASTHMA ADVENTURE CAMP APPLICATION CHECK LIST

- Return Part one (Parents/Guardian) and Part two (Physician) of the application.
- Is everything filled out and signed by parent, physician and child?
- Is child's picture included? (school photo or head shot)
- The consent form must be signed by parent and child.
- Note - Immunization records required before child is accepted, make sure physician's office completes documentation section or a copy of your child's immunization record is included.
- Note – each camper is required to have the H1N1 Flu Vaccination if attending camp.
- If you wish to be considered for financial assistance, please send verification of reduced school meal program.
- Did you include the \$25 deposit fee, which will be returned after your child attends camp or will be counted towards the registration fee.

How did you first hear about asthma camp?

Parents/Guardian, please return completed forms to:

American Lung Association in Illinois

Asthma Adventure Camp

3000 Kelly Lane; Springfield, IL 62711

Fax – 217/787-5916 or Email a scanned copy to – lkilmer@lungil.org

Questions – call 1/800-788-5864



Asthma Adventure Camp

FOR OFFICE USE ONLY

1 =Intermittent 2=Mild Persistent
3=Moderate Persistent 4=Severe Persistent
Asthma Ranking _____
Social/Emotional Ranking _____
Other Notes _____

Date Rec'd _____

**Part One
CAMPER HEALTH FORM**

GENERAL INFORMATION (to be completed by parent/guardian)

Camper Name _____ Birthdate ____ / ____ / ____
Last First Middle Initial

Sex: Male Female Nickname _____ Age at Camp ____ Grade Entering in Fall ____

Please provide name and address of the school your child will be entering in the 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

() Cellular Telephone () Cellular Telephone () Cellular Telephone

E-mail E-mail E-mail

What county does your camper live in? _____ What T-shirt size for camper? (**Adult sizes only**) XS 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 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** If so, what year? _____
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 # _____

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 HEALTH HISTORY

(to be completed by camper's parent/guardian)

Most recent

immunization dates: DPT ___/___/___ MMR ___/___/___ Hepatitis B ___/___/___ Chicken Pox ___/___/___

Tetanus Booster ___/___/___ H1N1 ___/___/___ (Note – H1N1 required to attend camp)

Immunization record REQUIRED or child will be denied to attend camp.

Has your child had any of the following illnesses?

Measels Yes No Date: ___/___/___ Chicken Pox Yes No Date: ___/___/___

Rubella Yes No Date: ___/___/___ Mumps Yes No Date: ___/___/___

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 _____

* Please send sheets & blankets instead of sleeping bags.

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

Does your child use a spacer or holding chamber with his/her inhaler? Yes No If yes, which one? _____

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

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, liquid or pill)	STRENGTH	DOSAGE	FREQUENCY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What would you give your child for a headache? _____

What would you give your child for an upset stomach? _____

Does your child prefer liquid, tablet, capsule or chewable form? _____

* Please initial if it is ok to give your child these medications if needed. _____ We will call you if the symptoms persist.

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 _____
 How often would a parent or guardian have missed work to monitor your child's 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. How many courses have been taken? _____ Most recent date _____

(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 and others.)

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)	Date of Last Reaction
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____
_____	_____	____ / ____ / ____

FOODS? Yes No

Food	Reaction (be specific)	Age of Last Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does your child need to have special food preparation? Or can they just avoid food allergens? Please explain.

What has your physician advised you to do if an allergic reaction has occurred? _____

ANIMALS or INSECTS? Yes No

Animal or Insect	Reaction (be specific)	Age of Last Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____

What has your physician advised you to do if an allergic reaction has occurred? _____

PARENT/GUARDIAN AUTHORIZATION

PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in Asthma Adventure Camp, sponsored by the American Lung Association in Illinois, 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 Asthma Adventure Camp and the American Lung Association in Illinois 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 Asthma Adventure Camp and the American Lung Association in Illinois 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.

Name _____ Relationship to child _____
Please Print

_____/_____/_____
Signature of Parent or Guardian Date

RELEASE OF 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 may be required.

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 Work Phone (_____) _____

AUTHORIZATION TO RELEASE MEDICAL DATA

I do hereby authorize Asthma Adventure Camp and the American Lung Association in Illinois 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 (_____) _____

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, 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

Parent's Signature

Please have your child sign

I agree to abide by the Camper Code of Conduct

Camper's Signature

____/____/____
Date

PART TWO

ASTHMA CAMP MEDICAL HISTORY AND PHYSICAL EXAMINATION

(To be completed & signed by the child's healthcare provider)

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 (or attach copy of immunization record)

DT _____ Hepatitis B _____ H1N1 _____

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

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)

