CAMP Breathe Ezzzze CAMPER APPLICATION

(TO BE COMPLETED BY PARENT OR GUARDIAN & REVIEWED BY CHILD'S ASTHMA DOCTOR)

Application deadline: April 1 * Please print *

Camp Date: May 31- June 3, 2010• Tishomingo State Park - Tishomingo, MS

For more information, call Kathy Smith at 662-377-4706 or Kathy Haynes at 662-542-1002

Child's name _____
(First) (Middle) "Please signify name child goes by" (Last)

How did you learn about camp?_____

Date of Birth _____ Age _____ Gender: ☐ Boy ☐ Girl

Address _____

City _____ State_____County _____ Zip_____

Father's Name or Guardian _____EMAIL_____

Address _____City_____State_____Zip_____

Mother's Name or Guardian_____EMAIL _____

Address _____City_____State_____Zip_____

Father's cell/night phone_____ Father's work/alternate phone_____

Mother's cell/night phone_____ Mother's work/alternate phone_____

Emergency Contact _____Relationship to camper_____ Phone _____

Emergency Contact _____Relationship to camper_____ Phone _____

Height _____ inches Weight_____lbs.

T-SHIRT SIZE **YOUTH** SMALL MED LARGE

ADULT SMALL MED LARGE X-LARGE XX-LARGE

Please circle the appropriate size T-shirt for your child

GENERAL INFORMATION:

Has your child previously attended Camp Breathe Ezzzze☐ Yes ☐ No If yes, when:_____

Do you anticipate any activity restrictions for your child at camp? ☐ Yes ☐ No

If yes, please explain: _____

Does your child know how to swim? ☐ Yes ☐ No

Does your child wet the bed? ☐ Yes ☐ No Does your child have nightmares? ☐ Yes ☐ No

Does your child have any emotional or psychological problems? ☐ Yes ☐ No

If yes, is your child on medication for this condition? ☐ Yes ☐ No

Please explain: _____

_____

Child's Name_____

ALLERGIES: If your child has known food allergies and CANNOT eat a regular camp diet, please list the foods known to cause reactions: FOOD _____ REACTION _____

FOOD_____ REACTION_____

Please attach a list of approved foods if there are food allergies.

Is your child allergic to any medications? ☐ Yes ☐ No If yes, please list: _____

Is your child allergic to any inhaled medications? ☐ Yes ☐ No If yes, please list: _____

Has your child had previous allergy treatments? ☐ Yes ☐ No If yes, please explain: _____

_____

Has your child ever had an allergic reaction to latex? ☐ Yes ☐ No

Is your child allergic to any insects? : ☐ NO ☐ Yes please list _____

Please check any of the following that your child has problems with: ☐ Animals ☐ Clothing ☐ Materials

☐ Soaps ☐ Plants ☐ None ☐ Other _____

Please explain:_____

Does your child have difficulty administering his own daily medications? ☐ Yes ☐ No

If yes, please describe: _____

Please list any other medical or personal information you think we should know about your child: _____

_____

Has your child been hospitalized in the past year because of asthma? ☐ Yes ☐ No If yes, how many times? _____

Detail course of hospitalization: _____

_____

Has your child required any oral steroid medications (Prednisone, Medrol, Prelone, Pediapred) within the past year?

☐ Yes ☐ No If yes, steroids were used from: _____ to _____

Explain _____

Has your child ever required ICU admission for asthma? ☐ Yes ☐ No If yes, when? _____

Intubation? ☐ Yes ☐ No

Does your child have any of the conditions listed below?

Nasal / Sinus ☐ Yes ☐ No Explain: _____

Skin problems ☐ Yes ☐ No Explain: _____

Convulsions ☐ Yes ☐ No Explain: _____

Heart Disease ☐ Yes ☐ No Explain: _____

Diabetes ☐ Yes ☐ No Explain: _____

Glasses ☐ Yes ☐ No Explain: _____

Hearing loss ☐ Yes ☐ No Explain: _____

Prosthesis ☐ Yes ☐ No Explain: _____

List any other significant medical or psychological problems: _____

CURRENT MEDICAL TREATMENT CHART: **Child's Name**_____

Child's current asthma doctor: _____ Doctor's Phone #: _____

Doctor's address: _____

City _____ Zip Code _____

Is child on **DAILY** medications for asthma? ☐ Yes ☐ No

MEDICATIONS: Please indicate below medications usually required for this child's asthma.

ASTHMA

Medications	Dose	Frequency of Use

NASAL / SINUS

Medications	Dose	Frequency of Use

SKIN

Medications	Dose	Frequency of Use

OTHER

Medications	Dose	Frequency of Use

***DOCTORS: PLEASE FILL OUT THE FOLLOWING SECTION**

PLEASE REVIEW AND SIGN OFF ON THE ABOVE MEDICATIONS

LATEST PHYSICAL EXAM: Date _____ (Exam date must be within the last 3 months)

Abnormal findings _____

_____

LATEST PULMONARY FUNCTIONS: Date _____

	Value	Percent Normal for Child
Peak Flow		
FVC		
FEV 1		
FEF 25-75%		

Pulmonary functions are not required to participate in camp but if they have been performed, we would like the results.

To the best of your knowledge, is this child medically stable enough to attend Camp Breathe Ezzzze?

☐ Yes ☐ No

Signature of Doctor or Nurse Practitioner _____ **Date** _____

The camp fee is $100. Partial **scholarships are available**. All attendees will be required to pay a $25 non-refundable registration fee. The balance of $75 will be due by May 1, 2010. Scholarships in the amount of $75 may be granted to eligible applicants. Scholarships will be granted based on income. Applicants will need to submit a copy of proof of income. The federal poverty level information most currently available will be utilized to assess the need for assistance.

AGREEMENT:

I understand that my child must observe the same camp rules as other children. If my child fails to adhere to camp rules, I will be contacted to retrieve my child from camp. I hereby give my consent to my child being photographed, videotaped, and that the pictures may be used for the purpose of recording the camp experience and I further understand that these photographs or video pictures may be used in publicity, fund raising or other purposes by the American Lung Association of Mississippi, North Mississippi Medical Center, or sponsors.

I also give my consent for the administration of medications that are deemed necessary so the physician in charge may give treatment of any emergency nature to my child, if I cannot be contacted within what they consider a reasonable time.

I understand that my child must be covered under our own medical accident insurance. **A copy of proof of insurance certificate or medical care is attached.** In consideration of the services, which are rendered to the child named above, pursuant hereto, the following is a listing of any insurance policies we have in force on said child:

Insurance Company: **Policy / Group / Medicare / Medicaid Numbers**

_____ _____

_____ _____

This authorization shall be effective until the end of the camp period.

Child's Name_____

Parent/Guardian_____

Signature of parent / guardian _____

Date _____

Questions? Call Kathy Smith 662-377-4706 or Kathy Haynes at 662-542-1002

***Please mail or fax this application as soon as possible to:**
*** A school photo of your child must accompany your application**

Kathy Smith
NMMC/Women's Hospital
830 South Gloster St.
Tupelo, MS 38801
Fax 662-377-4907

www.nmhs.net/asthmacamp