

# CAMPER APPLICATION PACKET



**2009**

**Sunday- Wednesday  
June 14- 17, 2009**

at



**Rockport, Texas**

**DEADLINE FOR SUBMITTING ALL FORMS:  
MAY 15, 2009**

## **THE IMPORTANCE OF COMPLETING ALL CAMP FORMS**

Although it may seem like a lot of paperwork, the forms required by Camp Easy Breathers are necessary for the protection of your child and the camp. Your child's health is important. The information given on these forms must be thorough, accurate, and legible! If emergency care is required, this is the first place that the doctor or nurse will refer to.

The following pages contain the forms that must be completed and returned to us to complete your child's camp application. Please make sure you fill out all the questions to the best of your knowledge. If you have any questions or need help filling them out, please give us a call. All completed forms are required before we begin reviewing your child's eligibility for camp. Please refer to the Camper Application Guide before completing this packet. Please use the Application Check List on page 8 of the Application Guide to make sure you have all of the forms. Keep the guide for your information. Thanks again for your interest in our camp and we look forward to meeting you and your child!!

A few important points to remember:

- Pay special attention to the "Emergency Contact" information. List at least two people other than yourself that can be contacted in the event of an emergency.
- Remember to use area codes. In many instances one state can have multiple area codes!
- Include your child's eyeglass prescription on the medical form.
- Don't leave any information out. This is a time when "too much information" is preferable.
- When you take your child for his/her physical, make sure the doctor signs the form.
- **FINALLY, MAKE SURE YOU SIGN AND DATE ALL FORMS!**

Your organization will help the Camp Director prepare for your child's arrival.

*Eligibility for selection to attend Camp Easy Breathers is conditioned upon completion of all forms, releases, and applications contained herein, maintenance and the provision of a copy of the camper's health insurance card, and compliance with any and all requirements of these documents, the policies and procedures of Camp Easy Breathers and applicable law.*

*Camp Easy Breathers reserves the right to verify or re-verify the accuracy and completeness of such information.*

# **Camp Easy Breathers Health Form**

## A. GENERAL INFORMATION - to be completed by parents or guardians

NAME OF CHILD \_\_\_\_\_

PREFERS TO BE CALLED \_\_\_\_\_

Birthdate: \_\_\_\_\_ Sex: \_\_\_Female \_\_\_Male

Age at Camp \_\_\_ Present grade (or recent past grade) \_\_\_

Name(s) of Parents (or Guardians)

Father \_\_\_\_\_ Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Mother \_\_\_\_\_ Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

or Guardians \_\_\_\_\_ Phone Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

County \_\_\_\_\_

Are parents living together? \_\_\_ Yes \_\_\_ No

Are there any custody or visitation restrictions? If so, describe:

**IF NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY: (this must be filled out)**

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Name of child's physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Does your child currently see an asthma specialist? \_\_\_ Yes \_\_\_ No

If so, which type? \_\_\_ Allergist \_\_\_ Pulmonologist \_\_\_ Don't know

Name of child's asthma physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

**INSURANCE INFORMATION:**

**(MUST INCLUDE NUMBER AND ATTACH COPY OF INSURANCE CARD):**

What does your child have for medical insurance?

\_\_\_ PPO \_\_\_ HMO \_\_\_ Medicaid \_\_\_ Medicare \_\_\_ None \_\_\_ Don't know

Name of Health Insurance Plan \_\_\_\_\_

Policy or Group Number \_\_\_\_\_

Has your child attended this Camp before? \_\_\_ Yes \_\_\_ No

If so, for how many sessions? \_\_\_ sessions

Has your child attended other asthma camps? \_\_\_ Yes \_\_\_ No

If so, for how many years? \_\_\_\_\_

**B. MEDICATIONS** - to be completed by parent and preferably verified by physician

**PARENTS:** This list contains most asthma medications- please mark **ONLY** the medications that your child is taking.

The first list contains controller medications that are usually prescribed to be used every day.

**1. My child takes the following ASTHMA medications:**

X	Medication	Generic Name	Amount (puffs, tabs, caps, ampules, tsp, cc)	How often				Specific instructions
	Advair HFA 45/21	Fluticasone/Salmeterol Combination		1x/day	2x/day`			
	Advair HFA 115/21	Fluticasone/Salmeterol Combination		1x/day	2x/day`			
	Advair HFA 230/21	Fluticasone/Salmeterol Combination		1x/day	2x/day`			
	Advair 100/50 Diskus	Fluticasone/Salmeterol Combination DPI		1x/day	2x/day			
	Advair 250/50 Diskus	Fluticasone/Salmeterol Combination DPI		1x/day	2x/day			
	Advair 500/50 Diskus	Fluticasone/Salmeterol Combination DPI		1x/day	2x/day			
	Alvesco 80 mcg inhaler	Ciclesonide		1x/day	2x/day			
	Alvesco 160 mcg inhaler	Ciclesonide		1x/day	2x/day			
	Asmanex Twisthaler® 220mcg	Mometasone furoate Inhalation Powder		1x/day	2x/day			
	Flovent 44 mcg inhaler	Fluticasone MDI		1x/day	2x/day			
	Flovent 110 mcg inhaler	Fluticasone MDI		1x/day	2x/day			
	Flovent 220 mcg inhaler	Fluticasone MDI		1x/day	2x/day			
	Foradil Aerolizer	Formoterol DPI		1x/day	2x/day			
	Pulmicort Flexhaler 90mcg	Budesonide Inhalation Powder		1x/day	2x/day			
	Pulmicort Flexhaler 180mcg	Budesonide Inhalation Powder		1x/day	2x/day			
	Pulmicort Turbuhaler inhaler	Budesonide DPI		1x/day	2x/day			
	Pulmicort 0.25 mg Respules	Budesonide suspension		1x/day	2x/day			
	Pulmicort 0.50 mg Respules	Budesonide suspension		1x/day	2x/day			
	Q-Var 40 mcg inhaler	Beclomethasone HFA MDI		1x/day	2x/day			
	Q-Var 80 mcg inhaler	Beclomethasone HFA MDI		1x/day	2x/day			
	Singulair 4 mg sprinkle	Montelukast granules		1x/day	2x/day			
	Singulair 4 mg tab	Montelukast tab		1x/day	2x/day			
	Singulair 5 mg tab	Montelukast tab		1x/day	2x/day			
	Singulair 10 mg tab	Montelukast tab		1x/day	2x/day			
	Symbicort 80/4.5	Budesonide/Formoderol		1x/day	2x/day			
	Symbicort 160/4.5	Budesonide/Formoderol		1x/day	2x/day			

**Additional Specific Instructions:**

\_\_\_\_\_

\_\_\_\_\_

Does your child take the above medications everyday? \_\_\_\_\_

Does your child take the above medications only if having asthma symptoms? \_\_\_\_\_

The following list contains rescue medications that are usually prescribed to be used only as needed for asthma symptoms.

1. My child takes the following ASTHMA medications:

LIST #2								
X	Medication	Generic Name	Amount (puffs, tabs, caps, ampules, tsp, cc)	How Often?				Specific instructions
	Albuterol inhal soltn	Albuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Albuterol inhaler	Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Atrovent inhal soltn	Ipratropium inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Atrovent inhaler	Ipratropium MDI		1x/day	2x/day	3x/day	4x/day	
	Combivent inhaler	Ipratropium/Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Duoneb inhal soltn	Ipratropium/Albuterol combination inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Maxair Autohaler	Pirbuterol inhaler MDI		1x/day	2x/day	3x/day	4x/day	
	Bubbly Pred 5 mg/5 ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Orapred 5 mg/5 ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Orapred ODT	Prednisolone Tablets		1x/day	2x/day	3x/day	4x/day	
	10mg 15mg 30mg							
	Pediapred 5 mg/5 ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Prednisone liquid 5 mg/5 ml	Prednisone liquid		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 1 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 2 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 5 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 10 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prednisone tab 20 mg	Prednisone tab		1x/day	2x/day	3x/day	4x/day	
	Prelone 5 mg/5 ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	Prelone 15 mg/5ml	Prednisolone liquid		1x/day	2x/day	3x/day	4x/day	
	ProAir MDI	Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Proventil inhal soltn	Albuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Proventil inhaler	Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Ventolin inhal soltn	Albuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Ventolin inhaler	Albuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Xopenex MDI	Levalbuterol MDI		1x/day	2x/day	3x/day	4x/day	
	Xopenex inhal soltn 0.31 mg	Levalbuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Xopenex inhal soltn 0.63 mg	Levalbuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	
	Xopenex inhal soltn 1.25mg	Levalbuterol inhal soltn		1x/day	2x/day	3x/day	4x/day	

**(IF NEEDED Medications continued)**

X	Medication	Generic Name	Amount (puffs, tabs, caps, ampules, tsp, cc)	How Often?				Specific instructions
	Allegra caps 60mg	Fexofenadine HCL		1x/day	2x/day			
	Allegra tabs 180mg	Fexofenadine HCL		1x/day	2x/day			
	Allegra Oral suspension 30mg/5 ml	Fexofenadine HCL						
	Claritin tabs 10mg	Loratadine		1x/day	2x/day			
	Claritin D	Loratadine		1x/day	2x/day			
	Claritin Reditabs 10mg	Loratadine		1x/day	2x/day			
	Claritin Syrup 1mg/ml	Loratadine		1x/day	2x/day			
	Clarinetabs 5mg	Desloratadine		1x/day	2x/day			
	Clarinetabs Syrup 5mg	Desloratadine						
	Zyrtec liquid 5mg/5ml	Cetirizine Hydrochloride		1x/day	2x/day			
	Zyrtec tabs 5mg, 10mg	Cetirizine Hydrochloride		1x/day	2x/day			
	Astelin Nasal Spray	Azelastine HCL		1x/day	2x/day			
	Asterpro Nasal Spray	Azelastine HCL		1x/day	2x/day			
	Flonase Nasal Spray	Fluticasone Propionate		1x/day	2x/day			
	Nasonex Nasal Spray	Mometasone Furoate Monohydrate Nasal Spray		1x/day	2x/day			
	Omnaris Nasal Spray	Ciclesonide		1x/day	2x/day			
	Rhinocort Nasal Spray	Budesonide		1x/day	2x/day			
	Veramyst Nasal Spray	Fluticasone Furoate						
	Nexium 20mg 40mg	Esomeprazole		1x/day	2x/day			
	Prevacid 15mg 30mg	Lansoprazole		1x/day	2x/day			
	Prilosec 10mg 20mg 40mg	Omeprazole		1x/day	2x/day			
	Epi-pen Jr 0.15mg	Epinephrine HCL						
	Epi-pen Auto injector 0.3mg	Epinephrine HCL						
	Other			1x/day	2x/day	3x/day	4x/day	
	Other			1x/day	2x/day	3x/day	4x/day	
	Other			1x/day	2x/day	3x/day	4x/day	

**Additional Specific Instructions:**

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Does your child take the above medications everyday? \_\_\_\_\_

Does your child take the above medications only if having asthma symptoms? \_\_\_\_\_



**C. HISTORY OF ASTHMA** - to be completed by parent and preferably verified by physician

1) How long has your child had asthma? \_\_\_\_years

2) Hospitalizations:

- A) Has your child been admitted to the hospital for asthma? \_\_\_\_Yes \_\_\_\_No How many times total? \_\_\_\_  
How old was he or she each time? \_\_\_\_\_
- B) Has your child ever been in an intensive care unit for asthma? \_\_\_\_Yes \_\_\_\_No How many times total? \_\_\_\_  
How old was he or she each time? \_\_\_\_
- C) Has your child ever had to have a breathing tube placed or been on a ventilator (breathing machine) due to asthma?  
\_\_\_\_Yes \_\_\_\_No How many times total? \_\_\_\_  
How old was he or she each time? \_\_\_\_\_

3) Within this past year only, how many times has your child been: (list number of times)

- A) Taken to the emergency room or urgent care clinic because of asthma? \_\_\_\_\_times
- B) Admitted to the hospital for asthma? \_\_\_\_\_ times
- C) Absent from school because of asthma? \_\_\_\_\_days
- D) Taken to the doctor's office because of difficulty with his or her asthma? Do not include routine office visits:  
\_\_\_\_times
- E) In an intensive care unit for asthma? \_\_\_\_Yes \_\_\_\_No How many times total? \_\_\_\_

4) How many times (in the past year only) have oral corticosteroids been used for the control of your child's asthma? \_\_\_\_\_

*(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, OraPred, BubblyPred and others.)*

Date of most recent steroids prescription? \_\_\_\_\_

5) Who is responsible for giving your child's asthma medication at home?

\_\_\_\_Child \_\_\_\_Parent \_\_\_\_Both

6) Does your child use a peak flow meter? \_\_\_\_Yes \_\_\_\_No

If yes, what is your child's normal reading? \_\_\_\_\_

Does your child use it routinely? \_\_\_\_Yes \_\_\_\_No

If so, how often? \_\_\_\_time(s) a day \_\_\_\_time(s) a week

7) On a scale of 0-10, how bad is your child's asthma? (CIRCLE ONE NUMBER ONLY!)

(NO SYMPTOMS)      0 1 2 3 4 5 6 7 8 9 10      (SEVERE ASTHMA)

Describe any emotional effects you have observed in your child due to asthma:

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**D. HISTORY OF ALLERGIES** - to be completed by parent and preferable verified by physician

Is our child allergic to any MEDICATION? (Penicillin, sulfa, etc.)? \_\_\_ Yes \_\_\_ No

If yes, please list:

Medication Name	Reactions* <i>(be specific with the symptoms, how severe, when they start, etc.)</i>	Age of Last Reaction

Is our child allergic to any FOODS? \_\_\_ Yes \_\_\_ No

If yes, please list:

Food Name	Reactions* <i>(be specific with the symptoms, how severe, when they start, etc.)</i>	Age of Last Reaction

Is our child allergic to any ANIMALS? \_\_\_ Yes \_\_\_ No

If yes, please list:

Animal	Reactions* <i>(be specific with the symptoms, how severe, when they start, etc.)</i>	Age of Last Reaction

Is our child allergic to any INSECTS? \_\_\_ Yes \_\_\_ No

If yes, please list:

Insect	Reactions* <i>(be specific with the symptoms, how severe, when they start, etc.)</i>	Age of Last Reaction

*\*Reactions include: Severe total body reaction (anaphylaxis); shock; skin problems (hives, redness, blistering, itchy skin, swelling); breathing problems ( wheeze, cough, chest tightness); mouth problems (swollen lips, rash, tongue swelling, itchy); throat problems (swollen, itchy, scratchy); eye problems (swollen, itchy, watery); nose problems (itchy, runny, stuffy, sneezing); intestinal problems (abdominal pain, vomiting, diarrhea); behavior/sleep problems (stimulation, hyper, strange behavior, sleepiness, trouble sleeping)*

Was emergency treatment needed for any of the reactions listed above (e.g. 911, ER visit, Urgent Care, EpiPen)? \_\_\_ Yes \_\_\_ No

If so, explain:

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**E. OTHER INFORMATION - to be completed by parent**

**PLEASE MAKE SURE TO INCLUDE COPY OF IMMUNIZATIONS WITH YOUR APPLICATION FORMS**

Has your child had the following illnesses?

Measles?  Yes  No

Rubella?  Yes  No

Chicken Pox?  Yes  No

Mumps?  Yes  No

Date of most recent tetanus booster: \_\_\_\_\_

DPT, Polio and MMR immunizations up-to-date?  Yes  No

Specifically, does your child have any of the following problems?

Convulsive Disorders?  Yes  No

Hyperactivity?  Yes  No

Diabetes?  Yes  No

Heart Disease?  Yes  No

Fainting?  Yes  No

Bedwetting?  Yes  No

Discipline Problems?  Yes  No

Sleepwalking?  Yes  No

Constipation?  Yes  No

Learning Disability?  Yes  No

Depression?  Yes  No

Obsessive Compulsive Disorder?  Yes  No

Attention Deficit Disorder?  Yes  No

Are there any other medical problems or conditions your child has that the camp should know about?  Yes  No

If yes to any of the above questions, explain here:

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Has your child ever camped out with the family?  Yes  No

If yes, were there any problems?  Yes  No

If yes, explain:

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Does your child feel embarrassed at school or in public if he/she has to take an inhaler or a nebulizer treatment?  Yes  No

Do you anticipate any activity restrictions?  Yes  No

If so, explain: \_\_\_\_\_

Are there any present physical education restrictions at school?  Yes  No

If so, explain: \_\_\_\_\_

Is there anything else you feel camp staff should know about your child?  Yes  No

If so, explain:

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**HOW DID YOU HEAR ABOUT ASTHMA CAMP?**

**Please check one:**

Healthcare Provider's Office

School Nurse

Friend

Previous camper or camp staff

CHIPS Health Plan  Other Insurance/Health Plan

Internet/Web Site  Which web site? \_\_\_\_\_

Social Worker

Radio

TV

Newspaper

Magazine

ALA or AAFA

How often over the past 4 weeks has/have:	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Your child complained of being short of breath					
Exertion (such as running) made your child breathless					
Your child coughed at night					
Your child been woken up by wheezing and coughing					
Your child stayed indoors because of wheezing or coughing					
Your child's education suffered due to his/her asthma (during school)					
Your child's asthma interfered with his/her life					
Asthma limited your child's activities					
Taking his/her inhaler or other treatments interrupted your child's life					
You had to make adjustments to family life because of your child's asthma					

**CAMPER CARE INFORMATION**

Please answer all questions and provide as much information as possible so that we can best care for your child while at camp. Campers **will not** be denied camp participation based on this information.

What is your child's T-shirt size?

Child size: SM MED LG XLG      Adult size: SM MED LG XLG

Has your child been to camp before? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many times? \_\_\_\_\_

Has your child attended a week long camp? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, what camp? \_\_\_\_\_

Has your child ever slept overnight away from family? Yes \_\_\_\_\_ No \_\_\_\_\_

Is your child able to function at his/her age level? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, please describe \_\_\_\_\_

What is your child looking forward to the most at Camp Easy Breathers? \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

Is there anything we should know about your child that will make his/her adjustment smoother? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any special needs, comfort items or rituals? Please describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any activities your child should **NOT** participate in? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any bedtime/sleep habits (sleepwalking, bedwetting)? Yes \_\_\_ No \_\_\_ Please describe: \_\_\_\_\_  
\_\_\_\_\_

Does your child have a physical or mental limitation that would affect his or her camping experience? Please describe: \_\_\_\_\_  
\_\_\_\_\_

Are there any recent stressful events that your child has experienced that we should know about? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have any serious fears? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything else that we need to know to provide your child a safe and enjoyable week?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_

## **HIPAA RELEASE FORM**

Camp Easy Breathers has requested your child's personal and medical information for the purpose of providing medical care necessary during your child's stay at Camp Easy Breathers. Your child's privacy is protected by the Health Insurance Portability and Accountability Act (HIPAA), state law and Camp Easy Breathers' privacy policies. Your acknowledgement of the following statements permits us to care for your child during his or her stay.

I have provided Camp Easy Breathers with the requested personal and medical information and understand this information will be used by camp staff in the care and treatment of my child.

I understand my child's personal and medical information will be shared with camp staff to the extent necessary to provide care and treatment for my child and to protect the safety of my child.

I understand Camp Easy Breathers will share my child's personal and medical information with other medical personnel, on or off-site, in the event that emergency medical care is required.

I hereby authorize Camp Easy Breathers to use my child's personal and medical information for the reasons set forth above.

I understand that I may revoke this authorization at any time by sending written notice to the camp director, Aracely Bigelow, at Driscoll Children's Hospital, 3533 S. Alameda Street, Corpus Christi, Texas 78411, and that this authorization will automatically expire when my child's participation at Camp Easy Breathers terminates.

Name of Camper: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Parent or Guardian (printed name): \_\_\_\_\_

Parent or guardian (signature): \_\_\_\_\_

Date: \_\_\_\_\_

## **CAMPER INFORMATION FORM**

**THIS SECTION TO BE COMPLETED BY CAMPER, WITH ASSISTANCE ONLY AS NEEDED.**

1. What are you looking most forward to at camp? (Check all that apply and add others if you like.)

- |   |   |
|---|---|
| <input type="checkbox"/> - Arts and Crafts    | <input type="checkbox"/> - Seeing Old Friends       |
| <input type="checkbox"/> - Campfires          | <input type="checkbox"/> - Singing                  |
| <input type="checkbox"/> - The Dance          | <input type="checkbox"/> - Swimming                 |
| <input type="checkbox"/> - Fishing            | <input type="checkbox"/> - Trying New Things        |
| <input type="checkbox"/> - Kayaking/Canoeing  | <input type="checkbox"/> - Ropes Course ( Zip line) |
| <input type="checkbox"/> - Nature             | <input type="checkbox"/> - Other _____              |
| <input type="checkbox"/> - Making New Friends | <input type="checkbox"/> - Other _____              |

2. Are you worried about anything at camp? If so, what is it and how can we make it better? \_\_\_\_\_

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3. Is there anything else you would like us to know so we can make sure you have the best week of camp ever? \_\_\_\_\_

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# **GENERAL CONSENT & RELEASE FORM**

## **Page 1 of 2**

Child's Full Name: \_\_\_\_\_  
(First) (Middle) (Last)

1. Camp Easy Breathers and Camp Aranzazu, Inc., accept no responsibility for the loss, damage, or theft of property.
2. Applicant understands the importance of and assumes responsibility for notifying Camp Easy Breathers of any changes in the information contained herein, such as work and home phone numbers, work location, emergency contacts, medical information, etc.
3. Should the emergency contact listed on the Camper Application, during the camp session, leave his/her place of residence, the camp administration will be notified of where he/she can be contacted in case of emergency.
4. I understand and agree that my child may be photographed, audio or videotaped, and/or, interviewed during camp activities. I hereby give Driscoll Children's Hospital, Camp Aranzazu, Camp Easy Breathers, and the Coastal Bend Asthma Initiative the right to photograph, audio or videotape or otherwise record my child and the right to copyright, reproduce and/or publish any recorded likeness of my child in public relations activities and promotional materials including, but not limited to: newspapers, television, videotapes, internet, pamphlets and brochures. I agree to hold Driscoll Children's Hospital, Camp Aranzazu, Camp Easy Breathers, and the Coastal Bend Asthma Initiative and all other media free and harmless from any liability arising from photographing, videotaping, interviewing and the subsequent publication or broadcasting of my child's participation at the event.
5. I also agree that my child's medical records from Driscoll Children's Hospital may be examined to verify information collected about his/her asthma history. I agree to have my child complete pre and post camp questionnaires that will help evaluate the effectiveness of camp and to compile and assess national asthma medical information. I understand that all data will be analyzed in aggregate form protecting the confidentiality of my child.
6. The undersigned acknowledges and agrees that admission to Camp Easy Breathers as a camper is a privilege that carries with it many responsibilities. Camp Easy Breathers expects campers to participate, to the extent possible, in the activities of the camp and to co-exist in a cooperative spirit. Campers found with alcohol, illegal drugs, or weapons will be immediately dismissed without a refund. In addition, should a behavior or discipline problem affect the camp operations or other campers' enjoyment of Camp Easy Breathers., the undersigned acknowledges Camp Easy Breathers' right to dismiss those campers responsible for such disruption without a refund. If such a dismissal occurs, the undersigned further acknowledges acceptance of responsibility for ensuring the child's safe travel home in a timely manner.
7. The undersigned acknowledges and agrees that attendance at Camp Easy Breathers represents your understanding and acceptance of the rules and responsibilities set forth herein.

8. **RELEASE FROM LIABILITY** (*Please Read Carefully*)

**I understand that accidents, illnesses and injuries occasionally occur at participation at events such as Camp Easy Breathers and that serious personal injury and property damage may occur as a consequence thereof. By signing this Release from Liability, I warrant that my child is fully capable of safely participating in Camp Easy Breather and I expressly assume all risks of my child's participation, whether such risks are known or unknown to me at this time. I further agree, on behalf of my child, myself and our heirs, family, estate, administrators, executors, personal representatives and assigns to hold harmless and release Driscoll Children's Hospital, The Coastal Bend Asthma Initiative, Camp Easy Breathers, and Camp Aranzazu, and their affiliates, agents, servants, volunteers or employees from any liability**

**GENERAL CONSENT & RELEASE FORM**

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occurring while my child is attending Camp Easy Breathers and/or growing out or resulting from any injury to, sickness of, and/or damage to my child or the undersigned relating in any way to the presence at, or use of facilities, or participation in the activities of Camp Easy Breathers and Camp Aranzazu or caused, in whole or in part, by any act or omission of said organizations, or the agents, servants, or employees of any of them. I further release and waive any and all claims for damages that we may have or may hereafter acquire due to the use of the facilities of Camp Easy Breathers and Camp Aranzazu. The foregoing provision applies to all activities connected with Camp Easy Breathers including, but not limited to, activities on the campground property, canoeing/kayaking, and any and all other off-campground activities planned in accordance with my child's attendance at Camp Easy Breathers.

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date \_\_\_\_\_

## **ACKNOWLEDGEMENT OF BEHAVIOR POLICY**

Child's Full Name: _____	
<b>Policy:</b>	Management of camper behavior problems at Camp Easy Breathers.
<b>Objectives:</b>	<ol style="list-style-type: none"> <li>1. Provide a quality experience for all campers and volunteers.</li> <li>2. Minimize the risk of injury to campers and staff.</li> <li>3. Outline steps for management of extreme behavior problem.</li> </ol>
<b>Implementation:</b>	The staff may identify problem behavior as conduct that is disruptive to others at camp or appears harmful to other campers. The following lists specific examples of those behaviors, followed by intervention the staff may take to provide a solution to the problem in order to reach the given objectives.
<b>Examples of Minor Problems:</b>	Teasing, calling names, talking back to staff, failure to cooperate, speaking out of turn, interrupting.
<b>Examples of Major Problems:</b>	Kicking, hitting, biting, throwing things, spitting, taking other children's belongings, pushing, dunking in the pool, etc.
<b><u>Strike I</u></b>	<i>Intervening Staff: Cabin Counselors</i>
<b>Course of action:</b>	Call the behavior to camper's attention. Inform the camper of the consequences if the behavior continues ( <i>i.e.</i> , time out). Redirect the camper's attention.
<b><u>Strike II</u></b>	<i>Intervening Staff: Counselor, Camp Director, Camp Program Manager</i>
<b>Course of action:</b>	Possible time out. Staff explains to the camper that because s/he has continued the behavior, s/he will sit out of the group for several minutes or the remainder of the activity. A call will be made to the child's parent or legal guardian. Parent/Guardian will be asked for assistance in redirecting child's undesirable behavior.
<b><u>Strike III</u></b>	<i>Intervening Staff: Counselor Coordinator, Camp Director, Camp Program Manager</i>
<b>Course of action:</b>	Child will be sent home. A child is given two opportunities for behavior modification. If the inappropriate behavior is repeated after the call home the parent or legal guardian will be called to pick the child up, with any expenses incurred in picking up the child being solely the responsibility of the parent/guardian.
WE HAVE READ, DISCUSSED, AND AGREE TO THE ABOVE BEHAVIOR POLICY FOR CAMP EASY BREATHERS	
Child's Signature _____	Date _____
Signature of Parent/Guardian: _____	Date _____
Printed Name: _____	

## **GENERAL AUTHORIZATION FORM**

Child's Full Name: \_\_\_\_\_

### PERMISSION TO PARTICIPATE IN CAMP ACTIVITIES

I hereby give permission for my child to attend Camp Easy Breathers from June 14, 2009 to June 17, 2009. I understand that attending Camp Easy Breathers includes sleeping, eating, engaging in activities, and receiving medications or other treatments if applicable. I understand that my child may take part in certain physical activities offered by Camp Easy Breathers, including: wilderness programs, fishing, sports and games, horseback riding, swimming and other water activities, and the ropes course.

I do not authorize my child to participate in : \_\_\_\_\_

### AUTHORIZATION TO PROVIDE MEDICAL TREATMENT

I authorize the Camp Easy Breathers' medical staff to provide medical treatment to my child while he/she is at Camp Easy Breathers. I understand that an asthma specialist or attending physician, as well as trained asthma staff will be assigned to my child.

I understand that the attending physician assigned to my child will determine the times and prescription for my child's medical treatment, and my child's medication and treatment may be changed during his/her time at Camp Easy Breathers. I hereby authorize the attending asthma specialist to change my child's medication and treatment if it is considered to be appropriate.

I assume all risks in connection with provision of medication and treatment by qualified medical personnel of Camp Easy Breathers and I release and agree to defend and hold harmless Camp Easy Breathers, The Coastal Bend Asthma Initiative, Driscoll Children's Hospital, Camp Aranzazu, Inc., and their officers, agents, servants, volunteers and employees, from all liability, claims and causes of whatsoever nature, which may arise out of, or result from, this treatment or procedure.

### CONSENT FOR EMERGENCY MEDICAL TREATMENT

In case my child needs emergency medical or surgical care and treatment during his/her stay at Camp Easy Breathers., I consent for Camp Easy Breathers to render or arrange for any x-rays, anesthetic, medical, dental or surgical diagnosis or treatment and hospital care that Camp Easy Breathers' Staff deems necessary. I acknowledge and agree that I am responsible to pay for any and all emergency medical attention required by my child, which exceeds the medical treatment authorized above. I also agree to indemnify and hold Camp Easy Breathers, The Coastal Bend Asthma Initiative, Driscoll Children's Hospital, and Camp Aranzazu, Inc., **harmless** from any and all claims, damages, liabilities, judgments, including reasonable attorney's fees, arising from emergency medical treatment sought and provided to my child.

### PERMISSION TO APPLY SUNSCREEN

I authorize any staff at Camp Easy Breathers and Camp Aranzazu, Inc., to apply sunscreen to my child, for protection from the sun when needed.

I agree that I have read and understand the terms and agreements listed herein and in this Camper Application. I agree that the information set forth in this Camper Application is true and correct and agree to comply with the policies and procedures of Camp Easy Breathers set forth in this Camper Application.

Signature of Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

Printed Name: \_\_\_\_\_



**PHYSICIAN HEALTH FORM**  
**TO BE COMPLETED BY CHILD'S PRIMARY DOCTOR**

**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.**

HR \_\_\_\_\_ RR \_\_\_\_\_ Temp \_\_\_\_\_

**Child's full name** \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ B/P \_\_\_\_\_

Immunizations Dates: Tetanus Shot \_\_\_\_\_ 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 within the **PAST YEAR**? \_\_\_\_\_ **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 within the **PAST YEAR**? **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 within the **PAST YEAR**? \_\_\_\_\_ **Y / N** How many times? \_\_\_\_\_  
 Reason \_\_\_\_\_

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

Physical Examination \_\_\_\_\_ **Y / N**  
 Date of last physical exam \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Allergy Shots/testing \_\_\_\_\_ **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>	Depression _____ <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. 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)  
0      1      2      3      4      5      6      7      8      9      10 (SEVERE ASTHMA)

9. How well does this child relate to other children his/her age? \_\_\_\_\_

10. Cognitive level of child: Age appropriate: \_\_\_\_\_ Lower for age: \_\_\_\_\_

11. Are there any specific issues related to this child's coping with their illness? \_\_\_\_\_

12. Do you believe this child can function at camp with minimal assistance (2-3 counselors per 7-8 campers)    **Y / N**  
If child requires additional assistance, please describe. \_\_\_\_\_

13. Do you believe this child will require one -on-one counselor care for the entirety of camp?    **Y / N**  
To your knowledge, is this child at risk for endangering themselves or others? \_\_\_\_\_

**MEDICATIONS**

Please include asthma and non-asthma medications

<b>DRUG NAME (include if it is an inhaler, nebulizer or pill)</b>	<b>STRENGTH</b>	<b>DOSAGE</b>	<b>FREQUENCY</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**ALLERGY INFORMATION**

**Is this child allergic to any:**

**MEDICATION?**    \_\_\_ Yes \_\_\_ No

<b>Medication</b>	<b>Reaction (be specific)</b>	<b>Age of Last Reaction</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**FOODS?**    \_\_\_ Yes \_\_\_ No

<b>Food</b>	<b>Reaction (be specific)</b>	<b>Age of Last Reaction</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**ANIMALS or INSECTS?**    \_\_\_ Yes \_\_\_ No

<b>Animal or Insect</b>	<b>Reaction (be specific)</b>	<b>Age of Last Reaction</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Printed Physician Name

\_\_\_\_\_  
Hospital/Institution affiliation of physicians

\_\_\_\_\_  
Office Address

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

Physician Telephone (24 hr. access necessary)

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

\_\_\_\_\_  
Date

# **CAMP SCHOLARSHIP FORM**

**Complete only if you are requesting a camp scholarship for your child. To be eligible for a camp scholarship this form must be complete and received with your completed camp registration forms. Please print clearly.**

Camper Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Camper's Social Security Number \_\_\_\_\_

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

Parent/Guardian: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Relationship to Camper \_\_\_\_\_

Address: Street Number \_\_\_\_\_ Apt. Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

How much of the registration fee can you afford to pay? \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Has this child received a previous camp scholarship?  Yes  No \_\_\_\_\_  
Year(s) Received

Are you currently receiving medical assistance?  Yes  No

If yes, what kind? \_\_\_\_\_ Case Number \_\_\_\_\_

**Do not complete the following four questions if you receive medical assistance or public assistance:**

1. What is the total monthly income for the family (include wages and other income sources)? \_\_\_\_\_
2. What are the total monthly expenses for the family (include housing, food, daycare, loans, etc)? \_\_\_\_\_
3. What is the average spent each month on medical expenses? \_\_\_\_\_
4. How many total family members do you support? \_\_\_\_\_

**BASIC SCHOLARSHIP CRITERIA**

- Camperships must be complete and received by the orientation date.
- Both financial need and severity of asthma will be used to determine eligibility and amount of support. In order to support the maximum number of campers, partial scholarships may be awarded.
- First and second year requests will be given priority.

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

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