Staple or tape recent photo here

APPLICATION INSTRUCTIONS

1. **Complete the application and return it to the address listed below.**

   American Lung Association of Arizona
   Attn: Camp Director
   102 W. McDowell Road
   Phoenix, AZ 85003

2. **Please do not leave any questions or sections blank.**

3. **Please attach a photocopy of your child's medical insurance card and immunization record with this application**.

4. **Please return this application by May 4th[th] OR UNTIL CAMP IS FULL (PLEASE call the director to verify)**

CAMPER APPLICATION

NAME OF CHILD ____

PREFERS TO BE CALLED ____

Birthdate _____________ Sex: ___Female ___Male

Age At Camp _________ Present grade (or last grade) ____

Name(s) of Parents/Guardians

Father ____________________ Phone: Home (___)___________ Work (___)______________

Cell (___) ________________ Email _________________________

Mother ___________________ Phone: Home (___)___________ Work (___)______________

Cell (___) ________________ Email _________________________

Guardians ________________ Phone: Home (___)___________ Work (___)______________

Cell (___)_________________ Email _________________________

MAILING ADDRESS (address of the parent or guardian that the child lives with)

Street____

City____________________County________________ State_______ Zip Code_________

School Name ____

Are parents living together? ___ Yes ___ No

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

____

EMERGENCY CONTACTS *(this __must__ be filled out)*

IF I AM NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:

I authorize the following person(s) to be contacted in an emergency, and give my permission to turn my child over to this person(s), if for any reason my child must leave camp and I cannot be reached.

Name _____________________________ Relationship to child ___________________________
Phone(___)___________________ Cell Phone(___)__________________________

Name _____________________________ Relationship to child ___________________________

Phone(___)___________________ Cell Phone(___)__________________________

PHYSICIAN INFORMATION

Who is your child's primary health care provider?

_____Pediatrician _____Family Practitioner _____Nurse Practitioner

_____Don't Know _____Other If other: _______________________

Name of child's regular physician ______________________________ Phone ___________________

Address: Street _________________________________ City_________________Zip Code________

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: Street _________________________________ City_________________Zip Code________

CAMPER INFORMATION

Check One:

Has your child attended this camp before? □ **Yes** □ **No** Please circle # of years 01 02 03

Camper's T-shirt size: **__Child sizes__:** □ **S** □ **M** □ **L** □ **XL** ***OR*** **__Adult sizes__:** □ **S** □ **M** □ **L** □ **XL**

How did you hear about Camp-Not-A-Wheeze?
□ **Media** □ **Friend** □ **Doctor/Nurse** □ **Camp Brochure** □ **Other** _________________________

HEALTH INSURANCE INFORMATION

Name and address of Insurance Company ____

Phone Number ____________________ Policy Number _________________Group Number____________

If group insurance, specify company ____

Name of Parent/Guardian who insures child ____

(Please attach a copy of the front and back of your child's medical insurance card with this application.)

ASTHMA HISTORY

How long has your child had asthma?____

Who is responsible for giving your child's asthma medicine at home?____ Child____Parent____Both

Please list your child's known asthma triggers or things that make your child's asthma worse *(examples: exercise, colds, dust, mold, pollen, animals, smoke)* ____

Does your child use a peak flow meter to monitor his/her asthma? ____No ____Yes

If yes: What is his/her usual "best" peak flow rate? _____________

Child's height: ____________ Child's Weight: ______________

Does your child have a written asthma action plan? ____No ____Yes

If yes: Please attach a copy with this application.

Asthma Severity:

Has your child been in an intensive care unit for asthma? _____No ____Yes

If yes: How many times total? ________ *Date of last episode*__________________________

Does your child take any of the following daily control medicines? *Check any that they take.*

☐ Advair ☐ Symbicort ☐ Serevent ☐ Formoterol

Does your child get anti-IgE treatment (Xolair shots every few weeks) for their asthma? ____No ____ Yes

Does your child take any of the following daily inhaled steroids? *Check any that they take*

☐ Vanceril ☐ Beclovent ☐ Azmacort ☐ Flovent ☐ Asmanex ☐ Pulmicort

☐ Q-Var ☐ Other: __________

Asthma Control:

Does your child take their "quick-relief" or emergency inhaler (Albuterol, Proventil, Ventolin, ProAir, Xopenex) for asthma more than 2 times a week? ____No ____Yes

Does your child wake at night with asthma more than 2 times a month? ____No ____Yes

Has your child missed more than 5 days of school in this last year because of asthma? ____No ____Yes

Within this past year:

- Has your child been taken to the Emergency Room because of asthma difficulty? ____No ____Yes

  *If yes: How many times total?*_____ *Date of last visit* ______________________________

- Has your child been admitted to the hospital overnight for asthma? ____No ____Yes

  *If yes: How many times total?*_____ *Date of last admission*__________________________

- Has your child been given oral corticosteroids (like Prednisone, Medrol, Deltasone, Decadron, Pediapred, Prelone, Liquipred, Oralpred) to control your child's asthma? ____No ____Yes

  *If yes: How many times total?*_____ *Date of last time*______________________________

On a scale of 0-10, how bad (severe) has your child's asthma been over the last year? *Circle one number only!*

(NO ASTHMA) 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:

____

____

____

GENERAL MEDICAL HISTORY

Allergies:

Please check if your child has problems with any of the following. Describe usual treatment or explain further if necessary:

❑ animals (especially horses), insects (bees, wasps, hornets) ______________________________

❑ food (list specific foods to be avoided) ______________________________

❑ medications (penicillin, sulfa, aspirin) ______________________________

❑ other ______________________________

Immunizations:

You MUST include a copy of your child's immunization record to be considered for approval.

Is your child up to date on all immunizations? □ **Yes** □ **No**

If no what is missing? ______________________________

Other Medical Problems:

Please list and describe any other medical problems your child has, is taking any treatment for, or that will help the camp staff and doctors better care for your child.

____

____

____

____

____

____

____

____

____

Are there any activities your child should avoid at camp? If yes, please explain:

____

Does your child wet the bed? ______________ *(They can still attend camp, but please send extra bedding, any mattress covers used, or pullups.)*

Camper's Name ____________________________

CURRENT MEDICINES

At Camp Not-A-Wheeze, doctors are available 24 hours a day to manage your child's health. A complete list of all medicines used by your child will allow the doctors to better care for your child.

Please list all the medicines your child currently takes **EVERY DAY**, even when their asthma is under control. Also include any over-the-counter and non-asthma related medications taken regularly.

PLEASE MAKE SURE THAT THIS IS ACCURATE – WE WILL USE THIS LIST WHILE YOUR CHILD IS AT CAMP.

MEDICINE	HOW MUCH TO TAKE	WHEN TO TAKE	OTHER INSTRUCTIONS

CHECK LIST

Make sure you have enclosed the following:

- **Application filled out completely**
- **Photo of the child**
- **Copy of the Insurance Card**
- **Copy of the Immunization Record**
- **Deposit ($50)** (If there is an issue supplying this deposit in full please contact Kelly Szymanski 602-258-7505)