CAMP Breathe Ezzzze CAMPER APPLICATION

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

Application deadline: April 15 * Please print *

Camp Date: May 30- June 2, 2011• 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, 2011. 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