

# 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 28- May 31, 2012** • 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.

<b>T-SHIRT SIZE</b>	<b>YOUTH</b>	SMALL	MED	LARGE			
	<b>ADULT</b>	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: \_\_\_\_\_

For office use only

Registration Fee Received \_\_\_\_\_ Camp Fee Received \_\_\_\_\_ Scholarship Granted \_\_\_\_\_

**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** \_\_\_\_\_

**FEES AND SCHOLARSHIPS:** Child's Name \_\_\_\_\_

The total camp fee is \$100. Partial and full **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, 2012. Scholarships in the amount of up to \$75 may be granted to eligible applicants. Scholarships will be granted based on income.

**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:

<b>Insurance Company:</b>	<b>Policy / Group / Medicare / Medicaid Numbers</b>
_____	_____
_____	_____

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](http://www.nmhs.net/asthmacamp)

