Staple Photo Here

Date Rec'd: _____

FOR OFFICE USE ONLY
Scale: 1=Mild 2=Moderate 3=Severe

Asthma Rating _____

Social/Emotional Ranking _____

Other Notes _____

_____

CAMPER HEALTH FORM

GENERAL INFORMATION (to be completed by parents)

Camper Name _____ Birthdate ____/_____/_____
Last First Middle Initial

SEX: MALE FEMALE NICKNAME_____ Age at Camp _____Grade Entering in Fall _____

EMERGENCY CONTACT INFORMATION

Father: ____ Check if Primary Residence	Mother: ____ Check if Primary Residence	Guardian (s): _____ Check if Primary Residence
_____ Last First	_____ Last First	_____ Last First
_____ Address	_____ Address	_____ Address
_____ City State Zip	_____ City State Zip	_____ City State Zip
(_____)_____ Home Telephone	(_____)_____ Home Telephone	(_____)_____ Home Telephone
(_____)_____ Work Telephone	(_____)_____ Work Telephone	(_____)_____ Work Telephone
(_____)_____ Cell Telephone	(_____)_____ Cell Telephone	(_____)_____ Cell Telephone

Who will be the primary contact while your child is at camp?_____ Best # to call? (_____)_____

Who is (are) the legal guardians (s) for this child? _____

Are there any custody or visitation restrictions? **YES NO If** Yes, please describe _____

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

Name_____Relationship to child _____ Phone (_____)_____

Name_____Relationship to child _____ Phone (_____)_____

CAMPER INFORMATION

Has your child:

Attended this camp before?	Yes	No	Please circle years 01 02 03 04 05
Attended other asthma Camps?	Yes	No	Name and Location _____
Attended other residential non-asthma camps?	Yes	No	Name and Location_____
Camped with family or others?	Yes	No	Explain: _____
Ever been away from home and parents for four days or more?	Yes	No	Explain: _____
Suffered from homesickness?	Yes	No	Explain:_____
Been placed on any activity restrictions?	Yes	No	Explain:_____
Had any recent changes in their family?	Yes	No	Explain: _____
Any special concerns about your child at camp?	Yes	No	Explain: _____

ALL MEDICATIONS

Please include asthma and non-asthma medications
(to be completed by parent/guardian)

DRUG NAME (indicate if it is an inhaler, nebulizer or pill)	**STRENGTH**	**DOSAGE**	**FREQUENCY**

Health Care Provider and Insurance Information:

Health Care Provider: _____

Clinic Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____

Insurance Company _____ Member/Policy Number _____

HISTORY OF ASTHMA

How long has your child had asthma? _____ years
Does your child have any other medical conditions? Explain: _____

_____

WITHIN THE PAST 3 MONTHS, (on the average):
How many nights per week does your child wake up because of asthma or coughing? Nights per week _____
How much does your child's asthma interfere with exercise? ____ NONE _____ SOME _____ A LOT
How many days per week does your child need to use their reliever (rescue inhaler)? Days per week _____

WITHIN THE PAST YEAR ONLY, how many times has your child:
Been home from school because of asthma? Number of days _____
Went to the doctor's office because of difficulty with his/her asthma? Number of times _____
Been to the emergency room or urgent care clinic because of asthma? Number of times _____
Been on oral corticosteroids (e.g., Prednisone, Prelone, Pediapred)
How many times? _____ Most recent date: _____

WITHIN THE PAST 5 YEARS, has your child been:
Admitted to the hospital for asthma? ____ Yes ____ No How many times? _____ Age (most recent) _____
In an intensive care unit for asthma? ____ Yes ____ No How many times? _____ Age (most recent) _____
Intubated for asthma? ____ Yes ____ No How many times? _____ Age (most recent) _____
Has your child been hospitalized for any other reason? Explain: _____

PARENT/GUARDIAN AUTHORIZATION

This health history is correct, to the best of my knowledge, and the child described has permission to engage in all prescribed camping activities, except as noted by myself and/or the attending physician. In the event that I cannot be reached in an emergency, I hereby give permissions to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child named below.

Signature: _____ Date: _____

PARENT/GUARDIAN CONSENT

I/We (please print names) _____ in

Consideration of the fact that California FairPlay consents to the acceptance of my/our child, _____

_____ for Camp Kids Play, a residential camp for children with asthma, do

agree, authorize and give consent as follows:

A. My child may participate in all camp activities (as outlines on Camp Arroyo Release Form)
B. Camp Medical personnel may treat my child if he/she should experience an episode of asthma during camp
C. My child may be transported to local emergency room if necessary and be treated appropriately
D. My child may be transported from the basic camp facility for any special camp related activities

On behalf of myself, my heirs, administrators and assignees, I/We do hereby waive release and discharge forever Camp Kids Play and any and all persons, official, and organizations directly and indirectly affiliated with the camp, of and from any and all rights and demands for injuries or otherwise, which my child may incur or sustain while at, traveling to and from, or while participating in aforesaid Camp Kids Play.

Signature: _____ Date: _____

PUBLICITY RELEASE

I consent to my child and/or myself being photographed for purposes of recording the camp experience, and I understand that these photographs or videos may be used for publicity, fund-raising, promoting the camp or other related purposes.

Child's Name (please print) _____ Date _____

Parent (s) or Guardian (s) Signature (s) _____

Child's T-shirt Size (adult sizes) Small _____ Medium _____ Large _____

Return forms to:

California FairPlay
Attn: Alfred Brown, SR.
P.O. Box 683
Rancho Murieta, CA 95683
(916) 492-6260

How did you hear about the Asthma Camp? Friend ____ Doctor ____ Nurse ____ Flyer/Poster ____ Other ____

CONFIDENTIAL