



CHAMP CAMP 2010 – CAMPER APPLICATION

The ultimate summer camp for kids (ages 7 to 14) with asthma.
July 18-24, 2010
Glacier View Ranch • Ward, Colorado

Physician’s Section (page 16)

Special Notice - H1N1 Flu Vaccine: Your child is required to receive the H1N1 vaccine at least TEN (10) days prior to the start of Camp, if they have not already had it. Last summer, the difficult decision to close down our asthma camp was heart wrenching, but was for the safety of the children. Please help us protect our campers. **More information on page 14.**

ATTACH A RECENT PHOTO OF YOUR CHILD TO THIS PAGE.

The \$35 processing fee is non-refundable and to be submitted with this application. Please make check payable to: American Lung Association.

Final cost of camp is based upon your net income & number of exemptions. If you plan to apply for financial aid, complete and attach the enclosed *Financial Aid Form*.

HOW DID YOU HEAR ABOUT CHAMP CAMP (check one)?

- Healthcare Provider’s Office
- Friend
- Internet Search
- Radio
- Social Worker
- Past camper
- Flyer/Brochure
- TV
- School/School Nurse
- Camp staff
- American Lung
- Magazine
- Kunsberg School
- Called/emailed us
- Newspaper
- Other _____

CAMPER INFORMATION

Name of your child? _____

Nickname/preferred name _____

Birth date (month/day/year) ____/____/____

Age at time of Champ Camp 2010 _____ Present/former grade _____

Circle: Female Male

Child's ethnicity (circle) White African American Hispanic/Latino Asian Pacific Islander
Native American Other: _____

T-shirt size: Youth S Youth M Youth L Adult S Adult M Adult L Adult XL

Has your child attended Champ Camp in the past? Yes No If yes, how many summers? _____

Has your child attended other asthma camps? Yes No If yes, how many summers? _____

PARENT/GUARDIAN INFORMATION

Do you, the parent/guardian, have asthma? Yes No

Are parents living together? Yes No

Does anybody smoke inside your home? Yes No

Does anybody smoke inside your car while your child is present? Yes No

Please indicate where we should send camp-related mailings:

Mother's address Father's address Guardian's address

Mother's Contact Info:

Name _____

Home number _____ Work number _____

Cell number _____ Email _____

Mailing Address _____

City _____ State _____ Zip _____

County _____

Name of employer _____

Employer address _____

City _____ State _____ Zip _____

Father's Contact Info:

Name _____

Home number _____ Work number _____

Cell number _____ Email _____

Mailing Address _____

City _____ State _____ Zip _____

County _____

Name of employer _____

Employer address _____

City _____ State _____ Zip _____

Guardian's Contact Info:

Name _____

Home number _____ Work number _____

Cell number _____ Email _____

Mailing Address _____

City _____ State _____ Zip _____

County _____

Name of employer _____

Employer address _____

City _____ State _____ Zip _____

- Please describe any custody or visitation restrictions:

- Person designated to drop-off child or pick-up child from camp other than yourself:

Name _____ Relationship to child _____

Phone _____

Address _____ City _____ State _____ Zip _____

- Person **NOT** permitted to take child or pick up child from camp:

Name _____ Relationship to child _____

Phone _____

Address _____ City _____ State _____ Zip _____

- Person(s) to be contacted in case of an emergency:

Name _____ Relationship to child _____

Phone _____

Address _____ City _____ State _____ Zip _____

Name _____ Relationship to child _____

Phone _____

Address _____ City _____ State _____ Zip _____

CAMPER PHYSICAL EXAM/CARE HISTORY

Date of last physical examination _____

Name of child's primary care physician _____

Pediatrician Family Practitioner Don't Know Other

Primary care physician phone _____

Primary care physician address _____

City _____ State _____ Zip _____

Name of child's dentist/orthodontist _____ Dentist Phone _____

Does your child currently see an asthma specialist? Yes No

If yes, which type? Allergist Pulmonologist Don't Know

Name of child's asthma specialist _____ Phone _____

Address _____ City _____ State _____ Zip _____

Does your child have a specific asthma action plan? Yes No *If yes, please attach to application.*

Child's medical insurance (check one):

Private insurance (Blue Cross/Blue Shield; HMO; PPO) Medicaid (Medi-Cal in California)
 Other state public program None

Name of health insurance plan: _____

Policy or group number: _____

For Females Only:

Has she menstruated? Yes No

If not, do you anticipate that she will start her cycle for the first time this summer? Yes No

Has she been educated about menstruation? Yes No

If she has menstruated, is her cycle normal? Yes No

Please describe any abnormalities or special needs: _____

MEDICATIONS

Please list all of your child's daily medications

Medication	Dose	Times per day	For what condition

Is your child on allergy injections? Yes No

NOTE: No allergy shots will be given at camp, unless there are special circumstances. Our Medical Director needs to approve allergy injections in advance.

ASTHMA HISTORY

1. How many years has your child had asthma? _____
2. Check all the symptoms you have noticed since your child started having trouble breathing:
 - Cough
 - Wheeze
 - Difficulty breathing while resting
 - Difficulty breathing with exercising: cough, tightness of chest, easily out of breath
 - Difficulty breathing at night: cough, chest tightness, wheezing during night
3. Check which time of year your child has the most difficulty breathing (cough, wheeze, chest tightness):
 - Fall
 - Winter
 - Spring
 - Summer
 - Year Round
4. Check which time of day your child has the most difficulty breathing (cough, wheeze, chest tightness):
 - Morning
 - Afternoon
 - Evening
 - During the Night
5. Check all of the factors that trigger your child to have trouble breathing, wheeze, cough, or have chest tightness:
 - Respiratory infections
 - Sinus infections
 - Exercise
 - Casual Activity
 - Vigorous Activity
 - Strong smells or Perfumes
 - Tobacco Smoke
 - Weather Changes
 - Cold Air
 - Excitement (including laughing and crying)
 - Allergens If yes, which ones _____
 - Animals If yes, which ones _____
 - Food If yes, which ones _____
 - Other _____
6. Any specific activities to be encouraged or limited by physician's advice? If so, please list:

7. Has your child ever been to the intensive care unit for asthma? Yes No

8. Does your child have a history of eczema? Yes No
9. Who is responsible for giving your child's asthma medication at home? Child Parent Both
10. Is your child allowed to carry his/her inhaler at school? Yes No
11. Does your child use a spacer/chamber/assisting device with his/her inhaler? Yes No

If so, what is the brand name of the spacer?

12. Does your child use a peak flow meter? Yes No
- a. If yes, what brand? _____
- b. 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

13. Within the past 3 months (*on average*):
- a. How often does your child wake up because of asthma or coughing?
 None Some A lot
- b. How much does your child's asthma interfere with exercise?
 None Some A lot

14. How many times in the past 12 months have oral corticosteroids been used for the control of your child's asthma (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: Prednisone, Medrol, Deltasone, Decadron (pills) and Pediapred, Prelone, Liquidpred, OraPred, BubbyPred (liquids)?

_____ courses of oral corticosteroids have been used in the past year

Date of most recent course? _____

15. How many times in the past 12 months has your child:
- a. Gone to the doctor for a non-urgent visit for his/her asthma? _____
- b. Gone to the emergency room for asthma? _____
- c. Missed school due to asthma? _____
- d. Missed school due to other illness? _____
- What kind of illness? _____

ALLERGIES HISTORY

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

If Yes, please list:

Medication Name	Reactions*	How long ago?

Is your child allergic to any FOODS? Yes No If Yes, please list:

Food Name	Reactions*	How long ago?

Is your child allergic to any ANIMALS? Yes No If Yes, please list:

Animal	Reactions*	How long ago?

Is your child allergic to any INSECTS? Yes No If Yes, please list:

Insect	Reactions*	How long ago?

**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 (911, ER visit, Urgent Care, EpiPen, etc.) needed for any of the reactions listed above?

Yes No If Yes, please explain:

OTHER HEALTH-RELATED MATTERS

Circle yes or no.

Headaches	Yes No		Seizures or Convulsions	Yes No		Hyperactivity	Yes No
Eating Disorder	Yes No		Diabetes	Yes No		Hypertension	Yes No
Frequent Ear Infections	Yes No		Constipation	Yes No		Heart Defects/ Disease	Yes No
Hearing Impaired	Yes No		Fainting	Yes No		Bleeding/ Clotting Disorders	Yes No
Vision Impaired	Yes No		Discipline Problems	Yes No		GERD (chronic heartburn)	Yes No
Learning Disability	Yes No		Depression	Yes No		Mononucleosis	Yes No
Obsessive Compulsive Disorder	Yes No		Bedwetting	Yes No		Hay Fever	Yes No
Attention Deficit Disorder	Yes No		Sleepwalking	Yes No		Ivy Poisoning	Yes No

Does your child have any chronic or recurring illness besides asthma? Yes No

Has your child had any operations or serious injuries? Yes No

Are there any other medical problems or conditions your child has that the camp directors/medical staff should be aware of? Yes No

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

BEHAVIORAL MATTERS

Please identify any concerns regarding your child's behavior that may assist the Champ Camp staff in providing your child with a positive summer camp experience.

If any, please describe your child's emotional, developmental or behavioral concerns:

Please describe any behavioral or emotional concerns for which your child is currently receiving psychological treatment or has received treatment for in the past:

If your child is currently taking medication for emotional or behavioral concerns, please list the medication and dosage: _____

Describe the symptoms for which the medication is prescribed: _____

If your child is receiving psychological treatment, counseling, or psychiatric medication, we will need to contact the treating clinician. Contacting your child's clinician will help us meet your child's special needs while at camp.

Please list the clinician's name and phone number, and sign the release below:

(Clinician's first and last name)

(Clinician's Phone Number)

Name of Child: _____

I give permission for _____ to communicate with American Lung Association staff regarding my child. (Clinician's name)

Parent or Guardian Signature

Date

Has your child ever camped with the family? Yes No

If yes, were there any problems? Yes No

If experienced any problems, please explain:

Has your child been to the mountains recently? Yes No

Any previous problems with altitude? Yes No

If yes, explain:

Has your child ever been away from home and parents for more than a few days? Yes No

If yes, were there any problems? Yes No If yes, what kind of problems occurred?

Do you anticipate any problems with homesickness at Champ Camp? Yes No

If yes, please describe: _____

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

Do you anticipate any activity restrictions? Yes No

If so, explain: _____

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

If so, explain:

PARENT'S AUTHORIZATION – Sign and date each section

RELEASE OF LIABILITY

THE UNDERSIGNED, ON HIS OR HER BEHALF AND BEHALF OF SUCH CHILDREN, HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE CHAMP CAMP/AMERICAN LUNG ASSOCIATION Southwest Region (ALASW), its directors, staff and volunteers (hereinafter referred to as "releasees") from all liability to the undersigned or such children and all their personal representatives, assigns, heirs, and next of kin for any loss or damage, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the releasees or otherwise while the undersigned or such children is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with CHAMP CAMP.

THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releasees and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned or such children in, upon or about the CHAMP CAMP premises or in any way observing or using any facilities or equipment of CHAMP CAMP or participating in any program affiliated with the CHAMP CAMP whether caused by the negligence of the releasees or otherwise.

THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE to the undersigned or such children due to negligence of releasees or otherwise while in, about or upon the premises of CHAMP CAMP and/or while using the premises or any facilities or equipment thereon or participating in any program affiliated with CHAMP CAMP.

Parent/Guardian Signature: _____ Date _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby give my permission to CHAMP CAMP officials to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency or medical or surgical care for my child, _____ should an emergency arise. It is understood that camp officials will make a conscientious effort to local the emergency contacts listed on the registration document before any action will be taken. If it is not possible to locate an emergency contact listed, I/we will accept the expense of emergency medical or surgical treatment.

Parent/Guardian Signature: _____ Date _____

PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE

I do hereby acknowledge and authorize CHAMP CAMP and the American Lung Association Southwest Region to take and use photographs, video and written comments of or by my child for promotional and informational materials. Further, I agree to release and discharge the American Lung Association Southwest Region and its sponsors from any and all liability in connection with the use of such photographs, videos and written comments of or by my child.

Parent/Guardian Signature: _____ Date _____

AUTHORIZATION TO PARTICIPATE OR EXCLUDE PARTICIPATION IN CAMP ACTIVITIES

I hereby give permission for my child to go on trips away from camp premises, whether on foot or by vehicle. I give permission for my child to participate in all camp activities with the following exceptions: _____

Parent/Guardian Signature: _____ Date _____

*The Camp Director will have a complete list of activities that will be included in your parent packet as camp draws closer. If there is a camp activity that you do not want your child to participate in after you review the list in your parent packet, please contact the director at 303.847.0270.

AUTHORIZATION TO RELEASE MEDICAL DATA

I hereby authorize CHAMP CAMP and the American Lung Association Southwest Region to release medical data for the purpose of compiling and assessing national asthma medical information. I understand that all participants' data will be combined and analyzed ("cumulatively" or "together") thereby protecting the confidentiality of my child.

Parent/Guardian Signature: _____ Date _____

H1N1 Flu Vaccine – Your child is required to receive the H1N1 vaccine before camp if they have not already had it at least TEN days prior to the start of Camp.

The Centers for Disease Control suggests “Everyone with asthma who is 6 months and older should get vaccinated against 2009 H1N1 with a flu shot. People with asthma who develop influenza – either seasonal flu or 2009 H1N1 flu - are at increased risk for serious complications and are more likely to be hospitalized. The flu may also make chronic health problems worse. For example, people with asthma may experience asthma attacks while they have the flu.” If your child has had flu symptoms within 10 days of camp, they will not be allowed to attend. Last summer, the difficult decision to close down all remaining asthma camps (including ours) occurring after July 15 because of H1N1 outbreaks across the country by our national organization was heart wrenching, but was for the safety of the children. We want to have a successful camp program this year and not be canceled. Please help us by protecting your child.

My child has received the H1N1 vaccination	YES	NO
My child has had probable or confirmed H1N1	YES	NO

2009/2010 H1N1 Influenza Virus (Swine Flu) Vaccination Agreement Form

To be signed by a parent or guardian of the child attending Champ Camp, the American Lung Association in Colorado camp for children with asthma. Signing indicates agreement

- 1) I understand the importance of protecting all participants of Champ Camp, including children, staff and volunteers from the harms of the H1N1 virus.
- 2) I understand that children with asthma and other respiratory problems are at a higher risk to get and have health complications due to the H1N1 virus.
- 3) I have or will have my child complete the full H1N1 virus vaccination a minimum of ten days prior to participation in Champ Camp for the 2010 year.

ACKNOWLEDGEMENT

_____, has had the complete full 2009/2010 H1N1 influenza vaccination ten days prior to participating in the 2010 Summer Champ Camp Program through the American Lung Association in Colorado. I understand participants of the camp will include other children, staff, and volunteers. I agree the American Lung Association in Colorado and/or its partners are not liable for any health reactions or problems that result or may result from my child taking this vaccination. My signature acknowledges that I have read and understand this form and agree to comply with it.

Parent or Guardian of Champ Camp Participant

Date

For more information or questions, contact American Lung at 303-388-4327, or champcamp@lungcolorado.org

CAMPER CODE OF CONDUCT – *Both Camper and Parent/Guardian must review, sign and date*

To help each camper get the most out of his/her camp experience, we have designed a list of ground rules. We recognize the special needs of our campers, and will (as much as possible) individualize the rules according to the needs and abilities of each camper.

Champ Camp has 5 basic rules. These rules are designed to protect the overall health of Champ Camp. It is our goal that each child returns home with fun memories... it is our mission to provide a quality environment and experience for all involved.

Rule # 1 - Respect yourself, others and property. "Respect yourself" means pick up your belongings, take care of personal hygiene and take your medication on time. Abusive behavior toward others or use of inappropriate language is not tolerated. Also, there will be no fighting, no stealing, no property damage, no graffiti and no vandalism at any time.

Rule #2 - Participate in all camp activities. It is camp's responsibility to know where every single camper is at all times. Campers are expected to be present at all activities unless excused by a staff member. Campers cannot be left alone in their cabins; therefore, if any camper is excused from an activity, he/she will be supervised by a staff member or by a nurse in the infirmary.

Rule #3 - Follow directions. There are a lot of fun things to do at camp, but every activity has guidelines so that camp can operate safely and appropriately. We expect the campers to follow staff direction during all activities.

Rule #4 - No put-downs (examples - teasing, name-calling, racial slurs, inappropriate jokes).

Rule #5 – Sticks and stones stay on the ground at all times.

Here is a breakdown of our camper-behavior-response policy:

- The counselor will start by giving the child a warning, and if that does not work, then a time-out with an explanation/discussion regarding the cause of the problem.
- If the counselor needs help, a behavioral specialist will work with the child to help avoid further problems.
- We may call home to discuss suggestions on ways to deter the inappropriate behavior. As a last resort, we may need to send a camper home.
- In the case of severe homesickness or if misbehavior is causing harm to anyone including the camper misbehaving, we reserve the right to send the camper home.

I understand and accept that my child must abide by the Camper Code of Conduct:

Parent/Guardian Signature

Date

I agree to abide by the Camper Code of Conduct:

Camper Signature

Date

Physician's Section for _____
Camper's Name

Please complete this form and fax to Attn: Champ Camp at 303.377.1102

Recommendations and Restrictions while at Champ Camp:

1. Communicable diseases, serious illnesses, and/or operations this individual has/had?
2. Treatment to be continued while at Champ Camp?
3. Medication to be administered at camp (specific dosages)?
4. Medically prescribed meal plan or dietary restrictions?
5. Drug reactions or allergies (food, drugs, plants, insects, etc.)?
6. Please give results of child's most recent PFT in table below. Date of PFT: _____

	Measured Value	% Predicted
FVC		
FEV1		
FEF 25-75%		

7. Child's Peak Flow Zones:
 Green Zone _____ Yellow Zone _____ Red Zone _____
8. Please rate the severity of his/her asthma?
 • Mild Intermittent • Mild Persistent • Moderate Persistent • Severe Persistent
9. Any disabilities or behavior problems? Yes No If yes , please explain: _____

I have examined the person herein described and have reviewed his/her health history. By signing below I am confirming that this child does indeed have asthma. It is my opinion that he/she is physically able to engage in camp activities, except as noted above.

 Physicians/Nurse Practitioner's Signature Date of Examination

 Physicians/Nurse Practitioner's Printed Name UPIN# Phone #