



**Statewide Overnight
Asthma Camp**
Camper Registration Packet
July 20 – 25, 2008



Dear Potential Camper:

The American Lung Association of Maryland offers this unique overnight residential camping experience for Maryland children ages 7 ½ to 12 with asthma. During the week of camp the campers will learn asthma management skills taught by Respiratory Therapists, they will participate in a wide variety of activities including but not limited to swimming, arts and crafts, self-esteem, and self confidence building skills.

Camp Superkids is held at the Carol Jean Cancer Foundation's Camp Friendship in Laytonsville, MD (Montgomery County). The camp is staffed 24-hours a day with registered nurses, registered respiratory therapists, physicians assistant and other non-medical support volunteers.

The attached **REGISTRATION PACKET** contains the following parts that need to be completed and submitted prior to **Friday, June 27, 2008**

- Application to be filled out completely by parents/guardians (Pages 2-5)
- Permission slip for use of name and photo (Page 6)
- Permission slips for Medical Transportation for Treatment (Page 6)
- Consent for administration of medications other than allergy/asthma drugs (Page 7)
- Health History Forms to be filled out completely by physicians (Pages 8-10)
- Scholarship Application (Page 11)

The cost of Camp Superkids is \$300.00. Contributions received from local companies and foundations have allowed us to keep the cost to a minimum. The actual cost is approximately \$900 per camper. The deposit of \$50.00 is due at the time of application – this fee will go towards the total cost of the camp. For those families in need, a Camp Scholarship Application is included in this packet (Page 11). If you choose to apply please make sure that page is included along with the supporting documents when submitting the registration packet.

**REGISTRATION DEADLINE:
FRIDAY, JUNE 27, 2008**

Completed Registration forms should be delivered to mailed to:

**American Lung Association of Maryland
Attention: Heather Dougherty
Executive Plaza I, Suite 600
11350 McCormick Road
Hunt Valley, MD 21031**

OR

Faxed to: 410-560-0829

If you have any questions or concerns please contact

Heather Dougherty
410-560-2120 ext. 224
800-642-1184 ext. 224

hdougherty@marylandlung.org

WE LOOK FORWARD TO SEEING YOU AT CAMP ON SUNDAY, JULY 20, 2008



Statewide Overnight Asthma Camp



Camper Registration Packet July 20 - 25, 2008

This form must be filled out completely by a parent or guardian. Provide detailed information to help us meet your child's needs. All information given is confidential and held for staff use only.

This form must be filled out completely and returned by Friday, June 27, 2008.

PERSONAL INFORMATION

Section #1

Child's Name: (Last) (First) (Middle) Sex: Male Female Age (at the time of camp): Birth Date: Home Address: (City) (State) (Zip) Home Phone: Has your child attended Camp Superkids before? Yes No If Yes, What Year(s) T-shirt size: M L XL XXL (All shirts are Adult Sizes)

Section #2

Medical Insurance Company: Policy Holder's Name: Policy Number: Expiration Date:

Section #3

Custodial Parent/Guardian: (camper lives with) Mother Father Both Other Mother/Guardian's Name: (Last) (First) Home Phone: Work Phone: Cell Phone: Email Address: Father/Guardian's Name: (Last) (First) Home Phone: Work Phone: Cell Phone: Email Address: Who would you like us to contact first? Mother/Guardian or Father/Guardian

Section #4

Please provide two emergency contacts other than parents. All attempts will be made to contact parent/guardian first. Name: Home Phone: Work Phone: Cell Phone: Name: Home Phone: Work Phone: Cell Phone:

HEALTHCARE PROVIDER INFORMATION

Section #5

Pediatrics/Doctor - Name: _____ Phone: _____
Allergist - Name: _____ Phone: _____
Pulmonologist- Name: _____ Phone: _____

HEALTH HISTORY

Section #6

Does your child have any of the following health concerns? (Please Circle Yes or No following each item)

Heart Disease – Yes No	Fainting – Yes No	OCD – Yes No
Diabetes – Yes No	Discipline Problems – Yes No	Sleep Walking – Yes No
Convulsive Disorder – Yes No	Bedwetting – Yes No	Sleep Apnea – Yes No
Learning Disabilities – Yes No	ADD/ADHD – Yes No	

Section #7

ILLNESS: Please mark an (X) next to any illness camper has had

Chicken Pox	Measles (red)	Mumps	Whooping Cough
Tuberculosis	Polio	Diphtheria	Pneumonia
Measles (4-day)	Rheumatic Fever		

Section #8

Please list below any recent hospitalization information or emergency room visits:

Date _____	Reason _____
Date _____	Reason _____
Date _____	Reason _____

Section #9

Is the camper exempt from any immunization on medical or religious ground?

Yes, provide a signed copy of Maryland DHMH Immunization Certificate from either a licensed physician indicating that the immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons.
No

Section #10

Does your child have any physical limitations (i.e., prosthesis, low endurance, recent surgery, etc.) which may affect his/her participation in any camp activity: No Yes

If Yes, please explain: _____

Section #11

Please list all medications, which your child takes. (Asthma Medications, Allergy Medications, Etc...)

Name of Drug

How Much and How Often

_____	_____
_____	_____
_____	_____

PARENT THOUGHTS

Section #14

Parents, please share your thoughts on the following questions:

Has your child stayed away from home and parents overnight? (Check one) Yes No

Length of stay (Check those which apply) 1 to 3 nights 1 week 2 weeks

Has your child had a fear of: (Check all that apply)

the dark	thunderstorms	water	fire
animals	being alone	heights	horses
being away from home	other _____		

Please share with us if your child is currently dealing with any special life issues such as divorce, a recent death, peer or school pressure, family illness, or alcohol, drug, or tobacco use.

Please list all sports, hobbies, crafts, and social organizations in which your child has participated or other activities your child enjoys, (i.e., baseball, soccer, collecting, model building, sewing, woodworking, boy scouts, 4H, etc.)

WATER ACTIVITIES: Does your child have any specific medically-related restrictions that will limit him/her from participating in water-type activities (i.e., swimming, canoeing)? *Please specify.*

Is there anything else that you feel would be helpful for us to know about your child?

Section #15

How did you hear about Camp Superkids? Please list the name where appropriate

Healthcare Office _____	Newspaper _____
School Nurse _____	Magazine _____
Friend _____	Internet Site _____
Previous camper _____	ALAM Event/Program _____
Camp Counselor _____	Other _____
Social Worker _____	

Thank you. This information will help us get to know your child before camp so we can make this a great camp experience for him/her.

Signature of Parent or Guardian

Date

Cancellation Policy

There is a \$50 non-refundable deposit due at the time the application is submitted. If your child is accepted and decides he/she will not be attending we must receive written notification by **June 30, 2008**. Following that, all camp costs will be owed to the ALAM. Any questions regarding this Cancellation Policy can be directed to Heather Dougherty, Camp Coordinator at 410-560-2120 ext. 224 or hdougherty@marylandlung.org



PERMISSION TO USE NAME AND PHOTO

Name of Camper: _____

School: _____

I hereby give permission to the American Lung Association of Maryland (ALAM) to use the name and/or photographs and/or video of my child, named above, for publicity or educational purposes. Publication may appear on the ALAM website, ALAM newsletters, and/or local public newspapers or other media outlets.

Parent or Guardian

Date Signed



PERMISSION TO TRANSPORT FOR TREATMENT

Name of Child _____

I hereby authorize the medical staff to transport my child named above to a hospital for emergency treatment. Parents/Guardian will be notified immediately.

Parent or Guardian

Date Signed

CONSENT FOR ADMINISTRATION OF APPROVED DISCRETIONARY MEDICATIONS

Name: _____ Date of Birth: _____

Medication Allergies/Sensitivities: _____

List any long-term medication your child receives: _____

I hereby give permission for my child _____ to receive any medication listed below on this form as deemed necessary. I have checked those medications I wish to be made available to my child. I understand that generic equivalent medications will be used in place of more expensive brand-name items.

Please check any medication you wish to be made available to your child:

For Headache/Fever/Earache/
Muscle Aches/Pain/Menstrual Cramps

For Bites/Allergic Rashes

For Sore Throat

Acetaminophen
(like Tylenol)

Anti-Itching Lotion
(like: Calamine)

Throat Lozenges

Ibuprofen (for menstrual cramps - 12 years and older)
(like: Advil)

For Upset Stomach

For Mild Allergic Reactions

For Coughs

Chewable Antacid Tablets
(like: Tums)

diphenhydramine
(like: Benadryl)

Cough Drops

I do not want any medication given to my child.

I understand that the above medications I have checked will be administered by the Camp Superkids Medical staff (registered nurse)

Signature of Parent/Guardian

Date

Home Phone: _____ Work/Emergency Phone: _____

TO BE FILLED OUT BY PHYSICIAN - CONTINUED

6. Do they take any medication before exercise? Please list.

7. Physical Examination (normal, abnormal)

Date _____ Height _____ ft. _____ in. Weight _____ lbs.

Blood Pressure _____/_____ Pulse _____/minute

Vision OD _____ Throat _____ Chest _____ Genitalia _____

O5 _____ Neck _____ Heart _____ Hernia _____

Skin Conditions _____ Lungs _____ Abdomen _____ Lymph nodes _____

Ears _____ Nose _____ Thyroid _____

8. How would you rate the severity of this child's asthma on a scale of 0-10?
(No Asthma) 0 1 2 3 4 5 6 7 8 9 10 (Severe Asthma)

9. When was this patient's last check-up and office visit? _____

10. GENERAL COMMENTS: _____

Pulmonary Studies – Personal Best Peak Flow (if known) _____

Does Patient have an "Asthma Action Plan"? _____ Yes _____ No - If Yes, please attach a copy

TO THE PHYSICIAN: The American Lung Association of Maryland and Johns Hopkins Bayview Medical Center are joining efforts to sponsor an overnight asthma camp for children that have asthma. The objectives of this program are to improve the child's physical condition and management of asthma and to enhance self-esteem and self-concept.

Doctor's Signature _____

Doctor's Name _____
(Please print)

Date _____ Phone (area code) _____ (Beeper #) _____
(only in event of immediate action)

Address _____
(Street)

(City)

(State)

(Zip)



Statewide Overnight Asthma Camp

Camp Scholarship Request July 20 – 25, 2008



SCHOLARSHIP REQUESTS

Are you in need of a Camp Scholarship? Yes _____ No _____

If you would like to request a financial scholarship please fill out this form completely. We will not be able to evaluate scholarship awards if we do not have all of the information listed below, as well as your completed application including doctor medical forms.

Camp Scholarships are for children with asthma between the ages of 7-1/2 and 12 years old, whose families need some assistance with the camp costs. The child must be a resident of Maryland to qualify for a camp scholarship through the American Lung Association of Maryland.

The funds that are available are very limited. The scholarships will be awarded on the level of need demonstrated as well as on a first-come first-serve basis. All scholarships will be awarded to first time campers before repeat campers. Deciding who is eligible for a scholarship is difficult. Anyone who receives a scholarship and the amount received is based on each individual campers situation.

It is very important that you answer the following statements fully.

Are you currently receiving medical assistance? Yes No
If yes, what kind?
Social worker's Name Phone Number:

Are you currently receiving any other form of public assistance (food stamps, etc...)? Yes No
If yes, what kind?
Social worker's Name Phone Number:

- 1. Total income of both parents or guardians.
2. Do you receive Child Support for the applicant? Yes No
3. Number of dependents (under age 21) living at address on application
4. Total cost of major medical expenses last year
5. How much of these medical expenses were paid by insurance?
6. Scholarships are limited. Please list the amount of the camp fee we will receive from you.
7. Please give any other comments that might qualify you for a scholarship.

- 8. To be considered for a scholarship you must attach any one of the supporting documents to the Scholarship Application:
• All recent W2 Statement(s) for each parent or guardian
• Previous years tax return for each parent or guardian

Remember, the funds are very limited. They will be awarded to those meeting the requirements on a first-come, first-serve basis and those who are first time campers. Please return the documents as soon as possible.