Breathe DC, Inc.
1310 Southern Avenue, SE
Washington, DC 20032
Phone 202.574-6789 Fax 202.373-5728

2016 CAMP APPLICATION
AND CAMPER/ PARENT/ HEALTH INFORMATION FORM

This form must be filled out **completely** by a parent or guardian, and returned **by June 30, 2016.**
Please note: space in the camp is limited and we urge you to complete and send in this application ASAP

To qualify for Camp Breathe Happy 2016, a child must meet the following criteria:

- Have a medical diagnosis of Asthma
- Be between the ages of 8 and 12 at the time camp starts (July 31st)
- Did not participate in Camp Breathe Happy's overnight camp in the past
- Be a District of Columbia Resident

REGISTRATION INFORMATION

Child's Name_____
(last) (first) (middle)

Sex: ☐ Male ☐ Female Age_____ Birth Date_____

Name of School that child attends _____

Parent/Guardian_____
(last) (first) (middle)

Relationship to Child_____

Home Address_____

_____ Ward _____

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Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: _____ E-mail: _____

If the parent or guardian is not available in an emergency during the camp week(s), please notify:

1. Name_____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

2. Name:_____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

HEALTH INSURANCE INFORMATION

Your child must have medical insurance to be eligible for Camp Breathe Happy. ☐
Please fill in the following:

Medical Insurance Plan_____

Name of Policy Holder _____

Policy Number_____ Group Policy Number_____

Billing Address_____

BACKGROUND INFORMATION

1. PARENT THOUGHTS: (Parents or guardians, please share your thoughts on the following questions).

a. How enthusiastic about attending camp is your child? *(Check one)*

☐ Very enthusiastic ☐ Undecided
☐ Enthusiastic ☐ Refuses to go
☐ Will attend

b. Has your child had any special problems associated with academic or social performance or behavior (e.g. learning disabilities, ADHD, frequently fights with others)? Please explain.

_____

_____

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

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_____

_____

d. 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.).

_____

_____

e. Does your child have any specific **medically-related** restrictions that will limit him/her from participating in physical activities (i.e. swimming, hiking, climbing)? (*Please specify)*

_____

f. Can your child swim? ☐ Yes ☐ No

HEALTH HISTORY

****PLEASE PROVIDE A COPY OF AN IMMUNIZATION RECORD & ASTHMA ACTION PLAN****

1. a. Name of camper's physician_____

   b. Type of physician: *(Check one)*

   ☐ Pediatrician ☐ Family doctor ☐ Allergist
   ☐ Pulmonary doctor ☐ Other *(Please specify)*_____

   c. Physician's office phone number: (_____)_____

2. ILLNESS: Which of the following has your child had? *(Check all that apply)*

   ☐ Chicken pox ☐ Tuberculosis ☐ Rheumatic fever ☐ Pneumonia
   ☐ Measles (4-day) ☐ Measles (red) ☐ Diphtheria ☐ Mumps
   ☐ Polio ☐ Whooping cough
   ☐ Other_____

3. Does your child have any medical conditions **other than** asthma (e.g. diabetes, heart condition, sleep apnea, major depression)? ☐ Yes ☐ No
   *(If yes, please specify)*_____

   _____

4. Are your child's immunizations current? ☐ Yes ☐ No

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5. a. How many times was your child hospitalized in the last year? _____

   b. Please list the dates and reasons for **any hospitalizations** in the last year.
   (If you need more space, please attach a separate sheet)

Date_____ Reason_____

Date_____ Reason_____

Date_____ Reason_____

6. a. How many trips to the emergency room did your child make in the last year? _____

   b. Please list the dates and reasons for **any emergency room visits** in the last year.
   (If you need more space, please attach a separate sheet)

Date_____ Reason_____

Date_____ Reason_____

Date_____ Reason_____

7. Does your child have any food allergies? ☐ Yes ☐ No
   (*If yes, please list foods and reactions)*_____

   _____

8. Is your child allergic to bee stings (i.e. requires the use of an epi pen in the event of a bee sting?)
   ☐ Yes ☐ No

9. Does your child have any other allergies? ☐ Yes ☐ No
   (*If yes, please specify*) _____

   _____

10. Does your child have **any** dietary restrictions (e.g. vegetarian)? _____

    _____

11. Does your child have any **physical** limitations (e.g. prosthesis, low endurance, recent surgery, etc.) that may affect his/her participation in any camp activity? ☐ Yes ☐ No

    *(If yes, please explain)*_____

    _____

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12. Please list **all** medications your child takes. Include **injectable drugs** if these are needed.
(If you need more space, please attach a separate sheet)

NAME OF DRUG	HOW MUCH and HOW OFTEN	PURPOSE
_____	_____	_____
_____	_____	_____
_____	_____	_____

13. a. Does your child use **any** drugs that must be injected into the skin or muscle? ☐ Yes ☐ No
b. *If yes,* can your child fully administer his/her injections? ☐ Yes ☐ No

14. How often does your child experience the following side effects from his/her medications?

Side Effect	How Often
☐ Headaches	_____
☐ Vomiting	_____
☐ Nausea	_____
☐ Unable to sleep	_____
☐ Rapid heartbeat	_____

☐ Other *(Please specify)* _____

☐ My child does not experience side effects

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CONSENT FOR ADMINISTRATION OF
APPROVED DISCRETIONARY MEDICATIONS

I hereby give permission for the camper _____ to receive any medication listed below on this form as deemed necessary. I have checked those medications I wish to be made available to the camper. 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 the camper:

For headache/fever/earache/muscle aches/pain/menstrual cramps
__ Acetaminophen (like Tylenol)
__ Ibuprofen (for menstrual cramps-age 10 yrs.

For bites/allergic rashes
__ Anti-itching lotion (like calamine)

For sore throat
__ Throat lozenges

For upset stomach
__ Chewable antacid tablets (like Tums)

For mild allergic reactions
__ Diphenhydramine (like Benadryl)

For coughs
__ Cough drops

I understand that Camp Breathe Happy medical staff will administer the above medications I have checked.

__ I do not approve any medication given to the camper.

Additional comments: _____

_____

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OTHER COMMENTS

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

_____

_____

_____

Thank you. This information will help acquaint us with your child prior to camp and will assist us in providing a positive camping experience for him/her.

Child's T-shirt size _____ (Choose from adult size S, M, L, XL)

_____ _____

Signature of Parent or Guardian Date

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CAMP BREATHE HAPPY
PARENTAL PERMISSION FORM
FOR MEDICAL INFORMATION

I, _____, parent of _____ do give permission to my health care provider to provide immunization records and other medical information about my child to Breathe DC for the purpose of attending Camp Breathe Happy.

Date Signed _____

Please fill out the attached form and send to:

Breathe DC

BY FAX TO: 202-373-5728
By Email to: pat@breathedc.org

BY MAIL TO:
Breathe DC, Inc.
Room G-082
1310 Southern Ave. SE
Washington, DC 20032
202.574.6789

Note: Space in the camp is limited. Breathe DC reserves the right to review and decide which applications are accepted.

Thank you!