



## Camper Application

The following information will help us provide a safe and pleasant experience for your child.  
Thank you for your cooperation in completing the application. Please print clearly.

\_\_\_\_\_  
Name of Camper \_\_\_\_\_  
Nickname

\_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Home Phone Sex Age Date of Birth

\_\_\_\_\_  
Mother's Name Address (if different from above)

\_\_\_\_\_  
Home Phone Work Phone Cell Phone

**Please  
attach  
photo  
of camper  
(required)**

\_\_\_\_\_  
Mother's Email

\_\_\_\_\_  
Father's Name

\_\_\_\_\_  
Address (if different from above)

\_\_\_\_\_  
Home Phone Work Phone Cell Phone

\_\_\_\_\_  
Father's Email

Please indicate shirt size (circle): **SM**(6-8) **MED**(10-12) **LG**(14-16)





## Asthma History

When was your child first diagnosed with asthma?

What signals or symptoms does your child have that tell you an asthma attack is coming?

What is the frequency of his/her attacks?

How many times has your child been hospitalized for an asthma episode? When and Where?

Do any of your child's relatives have asthma?

How many days has your child missed from the last school year due to asthma (2008-2009)?

What asthma programs have you and your child attended? When and Where?

## Home Environment/Personal

How many people live in the same house as your child?	YES	NO
Does anyone smoke in the house where your child lives? How many?	YES	NO
Are there any pets in the house where your child lives?	YES	NO
Does your child have any fears or situations, which make him/her unhappy?	YES	NO
Does your child have any learning disabilities?	YES	NO
If yes, please describe _____		
Does your child wear glasses?	YES	NO
Does your child wear any dental devices?	YES	NO
Does your child have any swimming experience?	YES	NO
Does your child need to wear earplugs when swimming?	YES	NO
Does your child have any activity limitations?	YES	NO
How much fluid does your child typically drink in one day? _____		

Comments \_\_\_\_\_





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## Allergies

Does your child have allergies? YES NO  
Does your child receive allergy injections? YES NO

A. Please list all medications you child is allergic to:

B. Diet restrictions or food allergies? Please list.

C. Allergies to soaps, detergents, tape, bees, poison ivy or oak? Please list.

D. Insect allergies? Please list.

Has a bee ever stung your child? YES NO

If you know, check the substances or groups of substances to which your child is allergic:

- |  |  |
|--|--|
| <input type="checkbox"/> Pollens           | <input type="checkbox"/> House dust      |
| <input type="checkbox"/> Feathers and down | <input type="checkbox"/> Dog hair        |
| <input type="checkbox"/> Perfume           | <input type="checkbox"/> Molds           |
| <input type="checkbox"/> Cat hair          | <input type="checkbox"/> Other, specify: |

Check any of the following that have caused your child to have an asthma attack:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Smoke             | <input type="checkbox"/> Air pollution        | <input type="checkbox"/> Hot weather       |
| <input type="checkbox"/> Cold weather      | <input type="checkbox"/> Fear                 | <input type="checkbox"/> Excitement        |
| <input type="checkbox"/> Anger             | <input type="checkbox"/> Laughing             | <input type="checkbox"/> Cold or infection |
| <input type="checkbox"/> Physical activity | <input type="checkbox"/> Worry/stress/anxiety | <input type="checkbox"/> Other, specify:   |

# Doctor's Permission Form

This form is to be completed by your physician.



Airways is a week-long day camp for kids with asthma. The camp is sponsored by Baltimore Washington Medical Center. The objectives of the program are to improve the child's physical condition and management of asthma and to increase self-esteem. In order for our respiratory therapists and pediatric nurses to effectively monitor each child's breathing status, we need the following information regarding his/her medications.

\_\_\_\_\_  
Camper's Name

\_\_\_\_\_  
Parent/Guardian

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Home Phone Parent's Work Phone

The following medication(s) must be given:

<u>Medication</u>	<u>Dosage</u>	<u>Time(s)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Acetaminophen ____ susp. ____ tab.	_____	prn

Administration (specify water, milk, food, etc.):  
This medication is to be administered only until (date):

For all medications, including those given at home, list all side effects which should be observed by camp personnel.

Medication taken before exercise, if any?  
Any restricted physical activities?

\_\_\_\_\_  
Doctor's name (please print) Phone number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Doctor's Signature Date





## Photo Release Form

To better inform the public about the programs offered by Baltimore Washington Medical Center, we are requesting your permission to send photographs of your child (and/or family if included) to our local media. Any publicity or promotional use of such pictures or films is to be in good taste and in accordance with accepted ethics of public relations.

*Baltimore Washington Medical Center has my consent to use my child's photo in media releases and for promotional activities. My child may be identified by name as a camper for the program photographed.*

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Camper's Name

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Signature of Parent/Guardian

Date

