CCYB – The Next Generation:
A Journey into Outer Space!

Get ready to join us on a space odyssey at Camp Catch Your Breath 2016. Join us as we explore the mysteries of outer space and asthma management. We have lots of fun activities guaranteed to provide a good-time for your child. Camp will begin on Sunday, July 24 and end Friday, July 29, 2016, at Jackson's Mill State 4-H Conference Center near Weston, West Virginia.

Your child will be required to bring **all** medications that he/she is currently taking with them to camp. Medications should be brought to camp in their **original prescription bottles**. Your child's medications will be stored in a medical drawer assigned to your child in the camp medical room. Medicines will be given according to the schedule specified by the parent and will be distributed by camp medical staff. **ALLERGY SHOTS WILL NOT BE GIVEN AT CAMP!**

We will be taking the campers on an off campus field trip this year. While on the field trip your child will be assigned to an adult (three kids to one adult) and will be provided a special t-shirt to wear. A special permission form for this is included in this packet. Campers are permitted to bring a minimal amount of spending money although it is not required.

We strongly advise that your child **DOES NOT BRING** electronic devices and gaming systems such as IPods, Gameboys, PSPs and digital cameras. CCYB is not responsible for lost or stolen items.

Enclosed are your child's registration materials. Please review and complete the materials. It is important that you provide us with your child's physician's contact information. This will allow our camp doctor to consult with your child's physician if necessary during camp.

In this registration packet, you will find:

1. Parent Permission Form
2. Enrollment Questionnaire
3. Release Form
4. Respiratory Health Survey
5. Scholarship Application (if needed)
6. Return Envelope

All forms are to be completed by a parent or guardian. Please return the forms in the enclosed envelope with your NON REFUNDABLE $70 registration fee (the registration fee is $80 if registering after June 17, 2016. Make checks payable to "Camp Catch Your Breath"). Mail to:

United Hospital Center
c/o Sonny Hoskinson, R.Ph.
327 Medical Park Drive
Bridgeport, WV 26330

Registration for the camp is limited to 70 children. The registration deadline is July 8, 2016. If you need further information please call me at the American Lung Association, (304) 342-6600 or Camp Director, Sonny Hoskinson at United Hospital Center, (681) 342-1560.

See you at Camp!

Chantal Fields

Chantal
(aka. Chantal Centofanti-Fields, Area Director, ALAM-A, Program Director, CCYB)

ASTHMA CAMP UNIVERSAL HEALTH FORM

A. GENERAL INFORMATION - *to be completed by parents*

NAME OF CHILD _____

PREFERS TO BE CALLED _____

Birthdate _____ Sex ___Female ___Male Age At Camp ____ Weight ____ Grade Entering in School Fall ____

Name(s) of Parents (or Guardians)

Father _____ Phone: Home (___)_____ Work (___)_____ Cell (___) _____

Email _____

Mother _____ Phone: Home (___)_____ Work (___)_____ Cell (___) _____

Email _____

Guardians _____Phone: Home (___)_____ Work (___)_____ Cell (___)_____

Email _____

MAILING ADDRESS _____ City_____ State_____ Zip Code _____

Are parents living together? ___ Yes ___ No

Are there any custody or visitation restrictions? If so, describe:

_____

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

Name _____ Relationship to child _____ Phone(___)_____

Name _____ Relationship to child _____ Phone(___)_____

HEALTH CARE PROVIDER INFORMATION

Who is your child's primary care MD?

___Pediatrician ___Family Practitioner ___Don't Know ___Other

If other: _____

Name of child's regular physician _____ Phone _____

Address _____ Email Address_____

Does your child currently see an asthma specialist? ___Yes ___No
If so, which type? ____Allergist ____Pulmonologist ____Don't Know

Name of child's asthma physician _____ Phone _____

Address _____ Email Address_____

INSURANCE INFORMATION

What form of medical insurance does your child have?

___PPO ___HMO ___Medic-Aid ____Medi-Cal ___None ___Don't Know

Name of Health Insurance Plan _____

Policy or Group Number _____

PRIOR CAMP EXPERIENCE

Has your child attended this Camp before**?** ____Yes ____No If so, for how many sessions**?** ____sessions

Has your child attended other asthma camps**?** ____Yes ____No If so, for how many sessions? ____sessions

Has your child ever been to an overnight camp? ____Yes ____No

T-shirt size: _____ S _____M _____L _____XL

PERSONAL

1. Does your child have any fears or situations which make him/her unhappy?
   _____
   _____

2. Does your child have any learning disabilities?_____

3. Does your child wear glasses? _____ or Contacts _____

4. Does your child wear any dental devices? _____

5. Does your child have any swimming experience? Please indicate:

   ___ No experience, great fear of water ___ Some experience, needs assistance
   ___ No experience ___ Often swims, needs little/no assistance

   Please indicate level(s) completed with Red Cross or Y.M.C.A.
   _____

6. Does your child have any special athletic interests?_____

7. Do you have a home computer? YES NO Work computer? YES NO

8. Do you have internet access? at Home YES NO or at School YES NO

9. May we contact you by email? Camper YES NO Parent YES NO

10. Email Address: Camper: _____

    Parent/Guardian: (HOME)_____
    (WORK) _____

B. MEDICATIONS - *to be completed by parent and preferably verified by physician*

1. My child takes the following ASTHMA medications EVERY DAY:

Medication	Generic Name	Amount (puffs, tabs, caps, ampules, tsp, cc)	How often				Specific instructions
			1x/day	2x/day	3x/day	4x/day	
			1x/day	2x/day	3x/day	4x/day	
			1x/day	2x/day	3x/day	4x/day	
			1x/day	2x/day	3x/day	4x/day	
			1x/day	2x/day	3x/day	4x/day	
			1x/day	2x/day	3x/day	4x/day	

Additional Specific Instructions:

_____

_____

_____

3. Other medications that your child takes:

Medication	Strength	Amount (puffs, tabs, caps, ampules, tsp, cc)	Regular or as needed?	How often?				Specific Instructions
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	
				1x/day	2x/day	3x/day	4x/day	

Additional Specific Instructions:

_____

_____

_____

Is your child on allergy injections? ____Yes ____No
****NOTE:** No allergy shots will be given at camp.

Does your child use a spacer or assisting device with his/her inhaler? ____Yes ____No

If so, which one? _____

Is there any medication treatment you prefer not be used at camp for your child?

_____

Does your child have a specific Asthma Action Plan? ____Yes ____No

If so, please attach to this form.

C. HISTORY OF ASTHMA - *to be completed by parent and preferably verified by physician*

1) How long has your child had asthma? ____years

2) Within the past 5 years:

A) Has your child been admitted to the hospital for asthma? ____Yes ____ No How many times total? ____

How old was he or she each time? ____

B) Has your child been in an intensive care unit for asthma? ____Yes ____ No How many times total? ____

How old was he or she each time? ____

3) Within the past three months (on the average):

A) How many nights per week, on the average, does your child wake up because of asthma or coughing?

____nights per week

B) How much does your child's asthma interfere with exercise?

____None ____Some ____Moderate ____A lot

4) Within this past year only, how many times did your child need to (list number of times)

A) Stay home from school because of asthma? ____days

B) Be taken to the doctor's office because of difficulty with his or her asthma (not including routine office visits)?

____times

C) Be taken to the emergency room or urgent care clinic because of asthma difficulty? ____times

D) Be admitted to the hospital for asthma? ____Yes ____No How many times total? ____

How old was he or she each time? ____

E) Be in an intensive care unit for asthma? ____Yes ____No How many times total? ____

How old was he or she each time? ____

5) How many times (in the past year <u>only</u>) have oral corticosterioids been used for the control of your child's asthma? *(Note: 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: PILLS: Prednisone, Medrol, Deltasone, Decadron and others LIQUIDS: Pediapred, Prelone, Liquidpred, OraPred, BubblyPred and others.)*

____courses of oral corticosteroids have been taken in the past year. Date of most recent course? ____

6) Who is responsible for giving your child's asthma medication at home?

____Child ____Parent ____Both

7) Does your child use a peak flow meter? ____Yes ____No If yes, what brand? _____

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

8) On a scale of 0-10, how bad (severe) has your child's asthma been over the last year? (CIRCLE ONE NUMBER ONLY!)
(NO ASTHMA) 0 1 2 3 4 5 6 7 8 9 10 (SEVERE ASTHMA)

Describe any emotional affects you have observed in your child due to asthma: _____

_____

How often over the past 4 weeks has/have:	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
Your child complained of being short of breath					
Exertion (such as running) made your child breathless					
Your child coughed at night					
Your child been woken up by wheezing and coughing					
Your child stayed indoors because of wheezing or coughing					
Your child's education suffered due to his/her asthma (during school)					
Your child's asthma interfered with his/her life					
Asthma limited your child's activities					
Taking his/her inhaler or other treatments interrupted your child's life					
You had to make adjustments to family life because of your child's asthma					

D. HISTORY OF ALLERGIES - *to be completed by parent and preferable verified by physician*

Is our child allergic to any MEDICATION? (Penicillin, sulfa, etc.)? ____Yes ____No

If yes, please list:

Medication Name	**Reactions*** ***(be specific with the symptoms, how severe, when they start, etc.)***	**Age of Last Reaction**

Is our child allergic to any FOODS? ____Yes ____No

If yes, please list:

Food Name	**Reactions*** ***(be specific with the symptoms, how severe, when they start, etc.)***	**Age of Last Reaction**

Is our child allergic to any ANIMALS? ____Yes ____No

If yes, please list:

Animal	**Reactions*** ***(be specific with the symptoms, how severe, when they start, etc.)***	**Age of Last Reaction**

Is our child allergic to any INSECTS? ____Yes ____No

If yes, please list:

Insect	**Reactions*** ***(be specific with the symptoms, how severe, when they start, etc.)***	**Age of Last Reaction**

**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 needed for any of the reactions listed above (e.g. 911, ER visit, Urgent Care, EpiPen?)?
____Yes ____No If so, explain:

_____

_____

E. OTHER INFORMATION - *to be completed by parent*

Has your child had the following illnesses?

Measles?	____Yes ____No	Rubella?	____Yes ____No
Chicken Pox?	____Yes ____No	Mumps?	____Yes ____No

Date of most recent tetanus booster: _____

DPT, Polio and MMR immunizations up-to-date? ____Yes ____No

Specifically, does your child have any of the following problems?

Convulsive Disorders?	____Yes ____No	Hyperactivity?	____Yes ____No
Diabetes?	____Yes ____No	Heart Disease?	____Yes ____No
Fainting?	____Yes ____No	Bedwetting?	____Yes ____No
Discipline Problems?	____Yes ____No	Sleepwalking?	____Yes ____No
Constipation?	____Yes ____No	Learning Disability?	____Yes ____No
Depression?	____Yes ____No	Obsessive Compulsive Disorder?	____Yes ____No
Attention Deficit Disorder?	____Yes ____No		

Are there any other medical problems or conditions your child has that the camp should know about? ____Yes ____No
If yes to any of the above questions, explain here:

_____

_____

Has your child ever camped out with the family? ____Yes ____No
If yes, were there any problems? ____Yes ____No If yes, 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 so, were there any problems? _____

Do you anticipate any problems with homesickness at asthma camp?

_____

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: _____

Are there any present physical education restrictions at school? ____Yes ____No

If so, explain: _____

Is there anything else you feel camp staff should know about your child? ____Yes ____No

If so, explain: _____

_____

HOW DID YOU HEAR ABOUT ASTHMA CAMP?

Please check one:

___ Healthcare Provider's Office ___ Social Worker ___ Radio ___ Internet/Web Site

___ School Nurse ___ TV ___ Newspaper ___ Magazine

___ Friend ___ Called or wrote to ___ Other _____

___ Previous camper or camp staff ___ ALA or AAFA

My child will be attending camp with a sibling/friend and would like to be placed in the same group as that sibling/friend.

Sibling/Friend Name _____

PARENT'S AUTHORIZATION

PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in Camp Camp Catch Your Breath, held July 23-29, 2016, sponsored by United Hospital Center and the American Lung Association, as parent/guardian I hereby release the Association, United Hospital Center, Ohio Valley Medical Center, Charleston Area Medical Center, Sistersville General Hospital, Cabell Huntington Hospital, The Health Plan, its Incorporators, Physicians, Board Members, Officers, Employees, Agents, Independent Contractors and Volunteer Workers from any liability for injuries which are sustained during the camp, **including any necessary transportation**. The child herein described has permission to engage in all scheduled activities except as noted by the physician or parent/guardian. I hereby give permission to the camp physician to initiate and provide any necessary treatments, including transporting to the nearest certified emergency facility. If hospitalization is required, the child is to be referred to an appropriate physician and all treatments will be at my expense.

Parent/Guardian Signature _____ Date _____

PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE

I do hereby acknowledge and authorize Camp Catch Your Breath and United Hospital Center and the American Lung Association, as parent/guardian I hereby release the America Lung Association, United Hospital Center, Ohio Valley Medical Center, Charleston Area Medical Center, Sistersville General Hospital, Cabell Huntington Hospital, The Health Plan 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 United Hospital Center and the American Lung Association, as parent/guardian I hereby release the Association, United Hospital Center, Ohio Valley Medical Center, Charleston Area Medical Center, Sistersville General Hospital, Cabell Huntington Hospital, The Health Plan 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 _____

RELEASE FOR TRANSPORT HOME

At the conclusion of camp, the camp staff may release my child to me or to the individual(s) designated below. Under no circumstances will your child be released to anyone not specified by you. Picture ID may be required.

Name _____ Relationship _____ Phone (___) _____

Name _____ Relationship _____ Phone (___) _____

Parent/Guardian Signature _____ Date _____

RELEASE FOR ADMINISTRATION OF NONPRESCRIPTION OVER-THE-COUNTER MEDICATIONS

I give permission for the medical staff at Camp Catch Your Breath to administer nonprescription over-the-counter medications such as pain relievers, fever reducers, bug sting relievers, etc. as deemed necessary by the camp doctor and/or nurse.

Parent/Guardian Signature _____ Date _____

RELEASE FOR PARTICIPATION IN FIELD TRIPS

I give permission for my child to participate in the Camp Catch Your Breath Field Trip.

Parent/Guardian Signature _____ Date _____

Camp Catch Your Breath
RESPIRATORY HEALTH SURVEY - 2016

CAMPER NAME: _____

DATE: _____

1. What symptoms do you experience when you have an asthma attack? (Be specific)

   _____

   _____

2. Have you had wheezing or whistling in your chest in the last 12 months? YES NO

3. Would you consider your asthma a) Mild b) Moderate c) Severe

4. How many times a month do you experience signs or symptoms of asthma? _____

5. How many times per week do you use an inhaler for shortness of breath or signs of an acute asthmatic episode? _____

6. How many times in the last year have you gone to the emergency room or been seen by a physician for an exacerbation of asthma? _____

7. How many times in the last year have you been hospitalized due to asthma? _____

8. How many days of school did you miss this year due to asthma? _____

9. Do you use a peak flow meter? YES NO

10. How often do you use a peak flow meter?
    a) Never b) Once a month c) Once a week d) A few times a week

    e) Once a day f) Twice a day

11. Do you think a peak flow meter can help you better manage your asthma? YES NO

12. Have you attended Camp Catch Your Breath before? YES NO

    If yes, how many years? _____

Thank you for taking the time to complete this survey.
Your responses will help us better understand your child's asthma.

2016 Camper Scholarship Application

Camper Name: _____

Parent/Guardian Name:_____

Parent/Guardian Marital Status (circle one):

Single Married Divorced Widowed Separated

1. Dependent(s): _____ DOB_____

2. Dependent(s):_____ DOB_____

3. Dependent(s):_____ DOB_____

4. Dependent(s):_____ DOB_____

5. Dependent(s):_____ DOB_____

Income Resources

Gross Wages (Mother) $_____ Child Support/Alimony$_____

Gross Wages (Father) $_____ Other Income$_____

(Unemployment, Social Security, Disability)

Total Yearly Household Income: _____

Does your child receive free or reduced meals at school? Yes No

Special Circumstances: Are there any special circumstances that you would like us to know about:

Signature (Parent/guardian):_____ **Date**:_____

Please return this form with your registration materials.