ASTHMA CAMP MEDICAL HISTORY AND PHYSICAL EXAMINATION

(MUST be completed & signed by the child's healthcare provider)

Asthma Medical History and Physical Examination Form

An important note to Healthcare Providers:

This Medical History and Physical Examination form is a **mandatory** part of your patient's asthma camp application. If applicable, please try to simplify the medication regime that the child follows during camp. For example: if a medication can be given TID, with meals, instead of QID (or BID instead of TID), this would be helpful for the child and the medical personnel. Furthermore, inhalation therapy with a nebulizer can be time consuming for the child at camp; please carefully review the child's need for this form of therapy. ***Allergy shots will not be given at camp***.

Child's name ______________________________ Height ____________ Weight ____________ B/P __________

Date of last physical exam or asthma appointment ____/____/____ Please attach a copy of patient's immunizations

****Last physical exam MUST take place after July 2019!**

HISTORY ***Please circle Yes (Y) or No (N)***

1. Is this patient under regular care? .... **Y / N** Date of last appointment ____/____/____
2. Have there been any hospitalizations for asthma in the PAST 5 YEARS? ...... **Y / N** How many? ____________
   Date of most recent hospitalization (month, year) ________/________
3. Has this child been:
   a. In the ICU or intubated because of asthma in the PAST 5 YEARS? **Y / N** How many times? ________
      Date of most recent ICU admittance or intubation? ____/____/____
   b. On oral corticosteroids within the PAST YEAR? .... **Y/N** How many times? ________
      Date of most recent course? ____/____/____
   c. Hospitalized for reasons other than asthma? .... **Y / N** How many times? ________
4. Has this child received the following tests or evaluations in the past year?
   - Health/Development History .... **Y / N**
   - Physical Examination .... **Y / N**
5. Does this child have any of the following problems?
   - Convulsive disorders .... **Y / N**
   - Hyperactivity .... **Y / N**
   - Diabetes .... **Y / N**
   - Learning Disabilities .... **Y / N**
   - OCD .... **Y / N**
   - Heart Disease .... **Y / N**
   - Fainting .... **Y / N**
   - Bedwetting .... **Y / N**
   - ADD .... **Y / N**
   - Other .... **Y / N**
   - Discipline Problems .... **Y / N**
   - Sleepwalking .... **Y / N**
   - Constipation .... **Y / N**
   - ODD .... **Y / N**

   Explain any "yes" answers ____
6. Does the Camp Healthcare team need to be aware of any of the following:
   a. Known medical problems, besides asthma? .... **Y / N**
   b. Known behavioral or psychological issues? .... **Y N**
   c. Foods that must be completely eliminated from this patient's camp diet? ...... **Y / N**
   d. Other allergy or sensitivity problems? .... **Y / N**
   e. Specific medication issues? .... **Y / N**
   f. Treatments you prefer **not** be used at camp? .... **Y / N**
   g. Restrictions/limitations on participation in any asthma camp activities? ...... **Y / N**

   Please explain any "yes" answers (please be specific) ____

   ____
7. Based on the NHLBI's guidelines severity classification, how would you classify this child's asthma?
   ☐ Intermittent Asthma   Persistent Asthma: ☐ Mild   ☐ Moderate   ☐ Severe
8. How would you rate the severity of this child's asthma on a scale of 0 – 10? (Circle one number only)

(NO ASTHMA) 0   1   2   3   4   5   6   7   8   9   10 (SEVERE ASTHMA)

CAMP SUPERKIDS
a camp for kids with asthma

MEDICATIONS

Please include asthma and non-asthma medications

DRUG NAME (include if it is an inhaler, nebulizer or pill)	STRENGTH	DOSAGE	FREQUENCY

ALLERGY INFORMATION

Is this child allergic to any?

MEDICATION? ☐ Yes ☐ No

Medication	Reaction (be specific)	Age of Last Reaction

FOODS? ☐ Yes ☐ No

Food	Reaction (be specific)	Age of Last Reaction

ANIMALS or INSECTS? ☐ Yes ☐ No

Animal or Insect	Reaction (be specific)	Age of Last Reaction

HEALTHCARE PROVDER'S AUTHORIZATION

I have examined the above camp applicant. My signature below indicates that I believe this patient is able to participate in an active camp program designed for children with asthma.

Healthcare Provider Signature

Printed Name of Healthcare Provider

Clinic or Office

( )
Telephone

Street Address

City State Zip Code

Date

Medication during camp: Medications are dispensed at each meal and at bedtime. We would prefer to give as many evening medications as possible with supper. If the evening medications must be given at bedtime, please indicate this below.

Name of Medication	**Route** *(Mouth, IV, SQ, etc.)*	**Dosages**	**Frequency** *(include even/odd days)*	**Circle the time of day to be given**
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
				AM NOON PM BED
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