MEDICAL PROVIDER FORM

****Form should be completed by camper's Healthcare Provider (MD/NP/PA)****

Camp Spinnaker
Helping kids with asthma soar

***An important note to Healthcare Providers*:** This 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. Allergy shots will not be given at camp.

Child's name _____

Date of last physical exam: _____
Height _____ Weight _____ B/P _____
Gender: _____

Immunization Dates:
DT _____ **Hepatitis B** _____.
MMR _____ **Chicken Pox** _____.

HEALTH 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:

   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?

   On oral corticosteroids within the PAST YEAR? Y / N

   How many times? _____

   Date of most recent course? _____

   Hospitalized for reasons other than asthma? Y / N

   How many times? _____

   Reason for hospitalization _____

4. Does the Camp Healthcare team need to be aware of any of the following:

   Known medical problems, besides asthma? Y / N
   Known behavioral or psychological issues? Y / N
   Foods that must be completely eliminated from this patient's camp diet? Y / N
   Other allergy or sensitivity problems? Y / N
   Specific medication issues? Y / N
   Treatments you prefer not be used at camp? Y / N
   Restrictions/limitations on participation in any asthma camp activities? Y / N

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

   _____

   _____

6. Based on the NHLBI's guidelines severity classification, how would you classify this child's asthma?

   ☐ Intermittent Asthma Persistent Asthma: ☐ Mild ☐ Moderate ☐ Severe

7. How would you rate the child's level of asthma control?

   ☐ Completely controlled ☐ Well controlled ☐ Somewhat controlled ☐ Poorly controlled ☐ Not controlled at all

MEDICATIONS

Please include asthma and non-asthma medications – attach list or additional page if needed

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 PROVIDER'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 (with date) Printed Name of Healthcare Provider

_____ (_____) _____

Clinic or Office Telephone

_____ _____

Street Address City State Zip Code

- ☐ **Please provide a copy of most recent physical and immunizations record.**
- ☐ Some of my other patients may benefit from attending Camp Spinnaker. Please send me a few brochures.