ILLINOIS Heart & Lung FOUNDATION

ASTHMA CAMP UNIVERSAL HEALTH FORM

GENERAL INFORMATION - *to be completed by parents*

NAME OF CHILD _____

PREFERS TO BE CALLED _____

Birthdate _____ ❑ Female ❑ Male Age at Camp _____ Present grade (or recent past grade) _____

Name(s) of Parents (or Guardians)

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

Email _____

Mother _____Phone: Home (____)_____ Work (____)_____ Cell (____) _____

Email _____

or Guardians _____Phone: Home (____)_____ Work (____)_____ Cell (____) _____

Email _____

Address _____ City_____ State___ Zip Code _____

Are parents living together? ❑ Yes ❑ No

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

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 _____

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 _____

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 this past year only, how many times did your child need to

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 take 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? _____

4) 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? _____

5) Who is responsible for giving your child's asthma medication at home? ❑ Child ❑ Parent ❑ Both ❑ Caregiver

6) 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

7) 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:

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

Name _____ Relationship to child _____ Phone (____)_____

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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 _____

Return to:

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