



Muskingum TB & Respiratory Clinic

711 Main Street • Zanesville, Ohio 43701

(740) 452 5401 FAX-740-452-4493

Dear Family.

Thank you for your interest in this year's Asthma Camp. The camp is coordinated by the staff from Rambo Memorial Health Center.

Enclosed are forms that must be completed and returned by June 16th to insure your child's place at camp.

Please complete :

1. Asthma Camp Universal Health Form. (4 pages)
2. Camper Code of Conduct AND the 3-part consent form
3. Have the child's physician complete the Medical History Form.

On the day of camp it is very important that you send:

- A. Child's medication and instructions for administration. (**RESCUE INHALER**)(This needs to be in a zip-lock bag labeled with child's name)
- B. A towel (Please bring towel to camp on both days)
- C. A swimsuit and shoes/flip flops that can get wet.(Please bring on Day 1)
- D. Please make sure your child wears appropriate shoes(preferably sneakers) No sandals for the planned activities.
- E. The bowling alley can be cold so please bring a sweatshirt.

Unless your child is on a special diet, lunch and snacks will be provided.

Parents are responsible for transporting the child to and from the camp location. If there are any changes in the transportation arrangements, the camp staff must be notified in writing by parent/guardian on the day of the change. Photo ID will be required for pick up.

****Absolutely NO cell phones** are allowed at camp. If your child needs to bring one, it will be kept with camp personnel and returned to the child at the end of the day.

Rambo Memorial Health Center Registered Nurses and administration staff will be staffing the camp. If you should have any questions please feel free to call our office at 452-5401.

Sincerely,

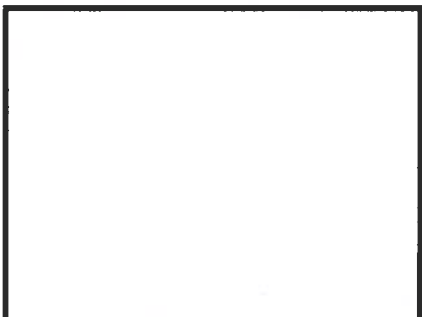
Shannon Bell BSN, RN

Executive Director

Staff Nurse, Rambo Health Center - Asthma Camp Coordinator



STAPLE PHOTO HERE



ASTHMA CAMP HEALTH FORM

711 Main Street
Zanesville, Ohio 43701
(740) 452-5401

A. GENERAL INFORMATION (to be completed by parents)

NAME OF CHILD _____

PREFERS TO BE CALLED _____

Birthdate _____ Female ___ Male ___ Age At Camp _____ Present grade _____

Name(s) of Parents (or Guardians) _____

Father _____ Phone: Home _____ Work _____ Cell _____

Mother _____ Phone: Home _____ Work _____ Cell _____

Guardian _____ Phone: Home _____ Work _____ Cell _____

Mailing

Address _____ City _____ State _____ Zip _____

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 completed)

Name _____ Relationship to child _____ Phone _____

Name _____ Relationship to child _____ Phone _____

Who is your child's primary care MD?

___ Pediatrician ___ Family Practitioner ___ Don't Know ___ Other

If other: _____

Who is your 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 _____

T-shirt size: Adult S ___ M ___ L ___ XL ___

T-shirt size: Youth S ___ M ___ L ___ XL ___

B. MEDICATIONS (to be completed by parent)

1. My Child takes the following medications EVERY DAY and as needed

Medication	Amount(puffs, tabs, caps, ampules, tsp, cc)	How often	As needed	Specific instructions

Is your child on allergy injections? ___ Yes ___ No

Does your child use a spacer or assisting device with his/her inhaler? ___ Yes ___ No

Additional Specific Instructions:

C. HISTORY OF ASTHMA (to be completed by parent)

In the last 6 months has your child been treated at an urgent care, emergency dept?

In the last 6 months has your child been hospitalized for an asthmatic incident?

Who is responsible for giving your child's asthma medication to them at home?

Can they self administer their medication? _____

Can they self administer with Nurse monitoring? _____

Do they need a Nurse to administer? _____

D. HISTORY OF ALLERGIES (to be completed by parent)

Is your child allergic to any **MEDICATIONS**? (Penicillin, Sulfa, ect.)? ___ 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 your 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 your 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 your 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 included: 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, Epi Pen)? ___ Yes ___ No

If so, explain: _____

E. OTHER INFORMATION (to be completed by parent)

Does your child have any of the following problems?

Convulsive Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hyperactivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Learning Disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discipline Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Obsessive Compulsive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Attention Deficit Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:

Do you anticipate any problems with homesickness a asthma camp?

Does your child feel embarrassed at school or in public if he/she has to use 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 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 was woken up by wheezing & 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					
Your child's asthma limited his/her activities					
Taking his/her inhaler or other treatments interrupted his/her life					
You had to make adjustments to family life because of your child's asthma					

HOW DID YOU HEAR ABOUT ASTHMA CAMP?

<input type="checkbox"/> Healthcare Provider	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Other
<input type="checkbox"/> School Nurse	<input type="checkbox"/> TV	
<input type="checkbox"/> Friend	<input type="checkbox"/> Radio	
<input type="checkbox"/> Previous camper	<input type="checkbox"/> Internet/Web Site	



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Camper Code of Conduct (Please review with your child)

It is our hope that everyone that participates in our program will have a positive experience that will last a lifetime. To help everyone get the most out of their camp experience, we have set up a list of ground rules to help parents and children understand what we expect at camp. We recognize the special needs of our campers and will, as much as possible; individualize the rules according to the needs and abilities of each camper.

Camp has four basic rules that we explain to the children. We have these rules so that everyone can be assured of a positive experience.

- **Respect yourself, others and property.** This means abusiveness toward others or using inappropriate language, fighting, stealing, etc. It also covers property damage, graffiti or vandalism. Respect yourself, refers to keeping your things picked up, personal hygiene and taking your medication on time.
- **Participate in camp activities.** It is camp's responsibility to know where all the campers are at all times. We ask campers to participate in all activities unless excused by staff. Campers cannot be left alone under any circumstances.
- **Follow directions.** There are a lot of fun things to do at camp but every activity has rules so we can operate the activity safely and appropriately. We ask the campers to follow staff direction during these activities.
- **No put-downs.** Examples of this would include teasing, name-calling, racial slurs or inappropriate practical jokes.

If we do have a problem with inappropriate behavior, we have a camper behavior response policy. The counselor will start by giving the child a warning, then a time-out with an explanation and discussion on what is causing the problem. As a last resort, we may need to send a child home. Sometimes in the case of severe homesickness or if misbehavior could cause immediate harm to themselves or others, we reserve the right to immediately ask that the child be removed from camp.

It is our hope that each child will go home with great memories of camp. These rules are designed to protect the camper's experience so that one unruly child will not ruin the experience for the rest. If you have any questions or comments, please feel free to call us 740-452-5401. It is our mission to provide a quality experience for everyone.

I understand and accept that my child must abide by the Camper Code of Conduct

Parent Signature _____ Date _____

Camper's Signature _____ Date _____



HEALTH CENTER
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PARTICIPATION AND EMERGENCY TREATMENT WAIVER

In consideration for being allowed to register and participate in Camp Wheeze Away, held 6/23/2026 and 6/24/2026, sponsored by Rambo Memorial Health Center, as parent/guardian I hereby release the Association, 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 nursing staff to initiate and provide any necessary treatment, 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. **Initial** _____

PHOTOGRAPHY, VIDEO AND PROMOTIONAL RELEASE

I do hereby acknowledge and authorize Camp Wheeze Away and Rambo Memorial Health Center to take and use photographs, video and written comments of or by my child for promotional and informational material. Further, I agree to release and discharge Rambo Memorial Health Center 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. **Initial** _____

RELEASE FOR TRANSPORT HOME

At the conclusion of camp, the Camp Staff may release my child to myself 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. **Initial** _____

Name _____ Relationship to Child _____

Parent sig. _____ Date _____ Phone _____

Parent/Guardian Signature _____

Child's Name _____ **Date** _____

Relationship to Child _____ **Phone** _____

Date Rec'd _____

ASTHMA CAMP MEDICAL HISTORY AND PHYSICAL EXAMINATION - to be completed by physician

Child's name _____ Height _____ Weight _____ B/P _____

Date of last physical exam ____ / ____ / ____

Immunization Dates:
DT _____

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? _____
- 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	Heart Disease Y / N	Discipline Problems Y / N
Hyperactivity Y / N	Fainting Y / N	Sleepwalking Y / N
Diabetes Y / N	Bedwetting Y / N	Constipation Y / N
Learning Disabilities Y / N	ADD Y / N	ODD Y / N
OCD Y / N	Other Y / N	Depression 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)

9. How would you rate the child's level of asthma control?
 Well controlled Not well controlled Very poorly controlled

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 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	Printed Name of Healthcare Provider
_____	() _____
Clinic or Office	Telephone
_____	_____
Street Address	City State Zip
_____	_____
Date	

Please return to: **Rambo Health Center**
fax 740-452-4493