

Please DO NOT MAIL this form. Bring it with you to camp.

Reviewed by Camp Staff (Initial): _____ Date: _____

The Master's Inn Health Services:

Asthma

THIS FORM MUST BE COMPLETED IN ORDER TO ATTEND CAMP

Please complete this form and bring it the day of check-in. Be sure to bring any necessary equipment and enough medications for the entire week. Peak flow meters are mandatory for asthma conditions. Non-compliance with the Doctor's orders or camp policies will result in dismissal from camp.

To be completed by parent or guardian:

Child's name: _____ Age: _____

History of present condition (including onset, triggers and treatment needed): _____

Please indicate the last time that each was needed to support breathing

- Fast-acting inhaler: _____
Nebulizer: _____
Hospitalization: _____

I understand that any child with a chronic health condition is more at risk in a new environment to have changes in their health status. I have been informed that the camp health center is a basic first aid station and NOT equipped for medical emergencies of a catastrophic nature. The time to reach such care may be delayed due to the distance of the nearest medical care facility. I know my child has a pre-existing condition and I will fully accept any financial responsibility incurred as a result of a decision by the staff of The Master's Inn to seek outside medical attention. I agree to allow my child to attend camp with the knowledge I have of my child's condition and the camp setting. I further understand that non-compliance with Doctor's orders and/or camp policies will result in my child's dismissal from camp without refund. I have provided any and all information to best help the staff of The Master's Inn care for my child in my absence.

Parent/guardian signature: _____ Date: _____

TO BE COMPLETED BY YOUR DOCTOR: Peak flow meters are mandatory to attend camp. Please indicate parameters below. Normal range: _____ Caution range: _____ Medical Alert: _____ Check any that apply to the above listed patient and indicate Rx and schedule of each: Long-acting Inhaler: _____ Fast-acting Inhaler: _____ Nebulizer Treatments: _____ PO medications: _____ Special instructions or restrictions: _____ Doctor's signature: _____ Date: _____