Grand Strand
Regional Medical Center
Life is a gift. Live it *well*.®

Spring 2012

Dear Potential Camper,

Thank you for your interest in Grand Strand Regional Medical Center's Camp Air Waves/Camp Seven Seas! Every summer we hold this camp especially for local asthmatic and diabetic children, offering fun field trips, unique crafts you can take home and useful education about how to manage your condition. Enclosed are the materials you will need to register for the summer 2012 day camp, held from 8:30 a.m. until 3:00 p.m., Tuesday, June 12th through Friday, June 15th. There is a mandatory orientation for parents on Monday, June 11h at 6pm.

The cost of educational camp is $25.00, which includes all lunches, field trips and crafts. Please complete the following forms and return them to us with your payment. Our mailing address, telephone and fax numbers appear at the bottom of this letter.

We must have all completed registration forms as well as your payment in order to reserve your space. If you have any questions, please call us at (843) 839-9933. Thank you again for your interest, and I look forward to speaking with you!

Kind regards,

Gina Burroughs
Community Wellness Coordinator
Grand Strand Regional Medical Center
Health*Finders*
Gina.burroughs@hcahealthcare.com

Mailing Address:
Health*Finders*
2000 Coastal Grand Circle #520
Myrtle Beach, SC 29577

Phone: (843) 839-9933
Fax: (843) 839-9932

Camp Air Waves / Camp Seven Seas

Parent Registration & Consent

I, _____ parent/legal guardian of

_____ hereby give my permission for the child named above to

participate in all activities of Camp Air Waves / Camp Seven Seas, 2012

with no exclusions _____

with the following exclusions_____.

Knowing that Camp Air Waves / Camp Seven Seas is a camp whose aim is to teach my child how to control their asthma or diabetes in a safe and fun environment, by signing this waiver I release the camp and all volunteer and paid staff from liability should an unforeseen accident occur while my child is at camp. I understand that the medical staff will provide my child with the best care they can should my child have a serious asthma or diabetes attack, or accident at camp, and by signing this, I release them from any liability for their care provided at camp. I understand that I may remove my child from camp at any time.

Also, by signing, I authorize the camp staff to administer the over the counter medications I have circled should my child need them according to the best judgment of the medical staff.

Tylenol/acetaminophen *Motrin/Advil* *Benadryl* *Calamine* *Sunscreen*

The camp will be held at the YMCA and may include a swimming activity. Any water activity will be supervised by CPR certified YMCA lifeguards.

My child **is** / **is not** (circle one) permitted to participate in a swimming activity.

My child **can** / **cannot** (circle one) swim.

Swimming level (circle one): non -swimmer beginner intermediate advanced

Parent or Legal Guardian's
Signature_____Date_____

In case my child develops a mild acute wheezing, I understand she/he will be treated with the appropriate inhaled or injected medication. In case of a medical emergency, I understand that every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the medical staff or authorized designee to hospitalize, secure proper treatment for and to order injection, anesthesia or emergency surgery for my child as named above.

Parent or Legal Guardian's
Signature_____Date_____

I hereby waive any claims against the sponsors, camp staff or volunteers for bodily injury, death or property damage, since I understand that being a passenger on a boat and other camp activities can be dangerous.

Parent or Legal Guardian's
Signature_____Date_____

I understand that physicians volunteering for camp will not require payment for services, but if hospital expenses are incurred or another physician is used, I understand I will be billed for these services. I also understand I will be billed for any prescriptions that need to be filled.

Parent or Legal Guardian's
Signature_____Date_____

I grant permission for Grand Strand Regional Medical Center to use my child's photo in newsletters or in the newspaper. YES_____ NO_____

My child's photo can be taken to be given to other campers. YES_____ NO_____

Parent or Legal Guardian's
Signature_____Date_____

Enclosed is a copy of my (check one): _____Insurance card

_____Military ID

_____Medicaid information

Enclosed is my check/money order for **$25.00** registration, payable to:

Grand Strand Regional Medical Center

T-Shirt size (circle one):

Child		M	L	
Adult	S	M	L	XL

PLEASE RETURN TO:

Health*Finders*
2000 Coastal Grand Circle
#520
Myrtle Beach, SC 29577
Attention: Gina Burroughs

FAX: (843) 839-9932

PLEASE RETURN AS SOON AS POSSIBLE. APPLICANTS ARE ACCEPTED ON A FIRST COME BASIS ONLY AFTER ALL THE REGISTRATION PAPERS HAVE BEEN RECEIVED.

CAMP AIR WAVES & CAMP SEVEN SEAS
GRAND STAND REGIONAL MEDICAL CENTER
809 82nd PARKWAY
MYRTLE BEACH, SC 29582
PHONE: 839-9933
FAX: 839-9932

SPONSORED BY:
GRAND STRAND REGIONAL MEDICAL CENTER
IN COOPERATION WITH:
AEROCARE MEDICAL EQUIPMENT

HEALTH HISTORY

To be filled out by parent or guardian. (PLEASE PRINT)

Camper's Name_____ Nickname_____

Address_____City_____State____Zip_____

Date of Birth_____Age_____Sex_____Height_____Weight_____

Doctor's Name_____Doctor's Phone_____

Doctor's Name_____Doctor's Phone_____

Responsible Party (Parents or Guardian)_____
Relationship to Camper

Parents' Work Phones_____/_____Home Phone_____/_____
Mother Father Mother Father

Alternate person (w/address) to be contacted in case of emergency_____

_____Relationship to Camper_____Phone_____

Is your child under a doctor's care for asthma? YES NO

Does your child do peak flow rates? YES NO
If you answer YES, what is your child's usual peak flow reading:_____

Is your child taking any medication that needs to be continued at camp? YES NO
If answer is YES, list below medication, dosage and usual times of day given:

MEDICATION	DOSAGE	TIME GIVEN	MEDICATION	DOSAGE	TIME GIVEN
1.			4.		
2.			5.		
3.			6.		

What medications do you give for acute asthma attacks?

MEDICATION	DOSAGE	HOW GIVEN
1.		
2.		
3.		

(continued on back)

Is your child allergic to any drug (Penicillin, Sulfa, etc.) YES NO
If answer is YES, list which medications:_____

Is your child allergic to bee stings? YES NO

Can your child fully participate without restriction in a camp program designed for children with asthma? If answer is NO, explain. YES NO
Limitations in activity:_____
_____

Does your child wheeze year-round? YES NO

Does your child wheeze certain months only? YES NO
Which months?_____
What makes your child wheeze?_____

Has your child had: Hives_____ Eczema_____ "Sinus"_____ Hay Fever_____
Drug Allergy_____ Frequent Colds_____ Frequent Bronchitis_____

Has your child been on a ventilator (machine to breathe for him/her) within the last year? YES NO

Was your child hospitalized (stayed overnight) in the past year for asthma? YES NO

If YES, how many times:_____Date of last hospitalization:_____

How many times in the past year has your child been to the Emergency Room for asthma?_____

What are the **first symptoms** your child has when an asthma attack is starting:

Cough_____ Chest tightness_____ Wheezing_____ Runny nose_____

Other symptoms:_____
_____

Number of days absent from school last year_____ Days due to asthma_____

Has your child been recently exposed to a contagious disease (chicken pox, measles, etc.) YES NO
If the answer is YES, what disease and when?_____

Has your child completed DPT series?_____ Date of last tetanus booster_____

Please list any other medical or emotional problems that the camp staff should know about_____
_____
_____

Did your child have any other previous medical problems or operations (include date)?_____
_____

Do you have any other comments about your child or his/her asthma?_____
_____
_____

(continued)

Is your child allergic to any foods? YES NO
If YES, please list_____
_____

Which foods must be completely avoided?_____
_____

Is your child allowed to have moderate amounts of candy and soft drinks? YES NO

PLEASE RETURN TO:

Health*Finders*
2000 Coastal Grand Circle
#520
Myrtle Beach, SC 29577
Attention: Gina Burroughs

FAX: (843) 839-9932

PLEASE RETURN AS SOON AS POSSIBLE. APPLICANTS ARE ACCEPTED ON A FIRST COME BASIS ONLY AFTER ALL THE REGISTRATION PAPERS HAVE BEEN RECEIVED.

CAMP AIR WAVES
GRAND STAND REGIONAL MEDICAL CENTER
809 82nd PARKWAY
MYRTLE BEACH, SC 29572

SPONSORED BY:
GRAND STRAND REGIONAL MEDICAL CENTER
IN COOPERATION WITH:
AEROCARE MEDICAL EQUIPMENT

ASTHMA CAMP MEDICAL FORM
PHYSICIAN'S FORM

Name of Child_____ Date of Birth_____
Address_____
_____ Phone #_____

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1) Is this child under regular medical care? Yes No
   How long has patient had asthma?_____

2) Diagnosis_____

3) Any known drug/food/insect allergies?_____
   (Note: No allergy shots will be administered at camp)

4) Any previous violent reactions from pollen/dust/dander/ requiring emergency treatment?

5) Please list medications routinely required by this child:

DRUG	**DOSE**	**TIME GIVEN**

6) Please list medications given on an as needed basis. (PRN)

DRUG	**DOSE**	**TIME GIVEN**

7) Have systemic corticosteroids (Prednisone, etc.) been required for control during the past year?
   Yes No If yes, give approximate dose and length of treatment.

_____

8) Does patient have a peak flow based asthma management plan? Yes No
   If yes, please attach a copy.

9) Does the child have a peak flow meter? Yes No
   What is patient's personal best peak flow rate?_____

10) Does patient have a history of recurrent sinusitis? Yes No

(over)

11) Can patient take penicillin? Yes No Sulfa? Yes No
Cephalosporins? Yes No Macrolides? Yes No

12) Has patient used a bronchodilator by metered dose inhaler in the past year? Yes No

13) Does the patient routinely use medication on his/her own? Yes No

14) Are there present diet restrictions? Yes No If yes, what? _____

15) Any hospitalization for asthma during the past year? Yes No
If so, any ICU admissions? Yes No Dates:_____

16) Has patient ever required ventilator support for asthma? Yes No
Any intubations? Yes No

17) Specifically, do any of the following problems exist?

a) seizures Yes No

b) cystic fibrosis Yes No

c) diabetes Yes No

d) heart disease Yes No

e) TB Yes No

18) Has patient been able to participate in regular physical education? Yes No
Would you recommend any restrictions at camp?_____

19) Is the family in need of financial assistance to send the child to camp? Yes No

Physician's Signature_____ Print Physician's Name_____
Address_____
Phone #_____ Fax #_____ Date_____

Fax form to GSRMC Health*Finders*: (843) 839-9932

CAMP SEVEN SEAS
GRAND STRAND REGIONAL MEDICAL CENTER
809 82nd Parkway
MYRTLE BEACH, SC 29572

SPONSORED BY:
GRAND STRAND REGIONAL MEDICAL CENTER
IN COOPERATION WITH:
Diabetes Self-Management Education Program

DIABETES CAMP MEDICAL FORM

PHYSICIAN'S FORM

Full name of camper_____ Nickname_____
Date of birth_____ Phone #_____
Address_____
_____

6) Is this camper under your regular medical care? Yes No Last visit_____
How long has patient had diabetes?_____

7) Other medical conditions_____

8) Any known drug/food/insect allergies?_____
(Note: Campers must bring all insulin & testing supplies needed during camp hours.)

9) Describe any previous insulin or other reaction requiring emergency treatment:_____
_____

5) Any hospitalization for diabetes during the past year? Yes No
If yes, dates:_____

6) Please list medications routinely required by this camper:

DRUG	**DOSE**	**TIME TO BE GIVEN**
Insulin (type)_____		
Insulin (type)_____		
Insulin (type)_____		

7) Please list medications given on an as needed basis. (PRN)

DRUG	**DOSE**	**TIME TO BE GIVEN**

8) Does patient have a sliding scale-based diabetes management plan? Yes No
If yes, please attach a copy.

9) Does the patient routinely insulin on his/her own? Yes No

10) Does the camper use an insulin pump? Yes No
If yes, can he/she operate the pump independently? Yes No

11) Are there present diet restrictions? Yes No If yes, what? _____
_____

12 Specifically, do any of the following problems exist?
a) seizures Yes No
b) cystic fibrosis Yes No
c) heart disease Yes No
d) TB Yes No

13) Has patient been able to participate in regular physical education/activities? Yes No
Would you recommend any restrictions at camp?_____

14) Is the family in need of financial assistance to send the patient to camp? Yes No

Physician's Signature_____ Print Physician's Name_____
Address_____
Phone #_____ Fax #_____ Date_____

Fax form to GSRMC Health*Finders*: (843) 839-9932