Camp Air Waves & Seven Seas
Health*Finders*
2000 Coastal Grand Circle, Suite 520
Myrtle Beach, SC 29577
Phone: 843.839.9933
Fax: 843.839.9932

2019 Camp Air Waves & Seven Seas
Parent Registration & Consent Form

I, _____ parent/legal guardian of _____
hereby give my permission for the child named above to participate in all activities for 2019 Camp Air Waves & Seven Seas (Please check one of the options below):

☐ with no exclusions.
☐ with the following exclusions _____

I understand that Camp Air Waves & Seven Seas is a camp that aims 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, all volunteers 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. 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.

Please return all forms and $25 payment to Health*Finders* by Thursday, June 6th. You may mail or drop forms off to Health*Finders* (inside Coastal Grand Mall near Dillard's) or fax them to 843.839.9932.

Mailing address: 2000 Coastal Grand Circle, #520 Myrtle Beach, SC 29577

Applications are accepted on a first-come, first-served basis.

Please sign and date the following statements:

1. If my child develops mild acute wheezing, I understand he/she 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 in this form.

   Parent or Legal Guardian's Signature: _____ **Date:** _____

2. I hereby waive any claims against the sponsors, camp staff or volunteers for bodily injury, death or property damage.

   Parent or Legal Guardian's Signature: _____ **Date:** _____

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

   Parent or Legal Guardian's Signature: _____ **Date:** _____

4. To ensure the safety of each child, Camp Air Waves & Seven Seas practices zero-tolerance for bullying behaviors. We expect your child to think of the feelings of others and be respectful – no teasing or put-downs. **Have your child agree and understand this statement. Please have them write their name here:**

   _____

5. I hereby grant Grand Strand Health permission to use my child's photo in newsletters, print, TV or digital media.

   ☐ YES ☐ NO

6. Camper T-shirt size (Please check one):

   Child: ☐ S ☐ M ☐ L

   Adult: ☐ S ☐ M ☐ L

   Would you like to purchase an additional camp T-shirt for your child for $8? ☐ YES ☐ NO

7. Enclosed is a copy of my (Check all that apply):

   ☐ Insurance card ☐ Military ID ☐ Medicaid information

The camp registration fee is $25. Checks can be made payable to: Grand Strand Medical Center

Health History

To be filled out by parent or guardian (Please PRINT)

Child's Full Name: _____

Name child would like to be called at camp: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____

Doctor's Name: _____ Doctor's Phone: _____

Doctor's Name: _____ Doctor's Phone: _____

Parent or Guardian: _____

Relationship to Child (Parent or Guardian): _____

Work Phone: _____/_____
(Parent or Guardian 1) (Parent or Guardian 2)

Cell or Home Phone: _____/_____
(Parent or Guardian 1) (Parent or Guardian 2)

Alternate contact in case of emergency: _____

Relationship to Child: _____ Phone: _____

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

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

	Medication	**Dose**	**Time Given**
1.			
2.			
3.			
4.			
5.			
6.			

I authorize camp staff to administer the over-the-counter medications I have checked below, should my child need them, according to the best judgment of the medical staff. Please check the options below:

☐ *Tylenol/acetaminophen* ☐ *Motrin/ibuprofen* ☐ *Benadryl* ☐ *Calamine* ☐ *Sunscreen*

Parent or Legal Guardian's Signature: _____ **Date:** _____

Is your child allergic to any drugs (Penicillin, Sulfa, etc.) ☐ YES ☐ NO

If **YES**, list which medications: _____

Is your child allergic to bee stings? ☐ YES ☐ NO

Is your child allergic to any foods? ☐ YES ☐ NO

If **YES**, please list food allergies: _____

_____

Which foods must be **completely** avoided due to allergy? _____

_____

Has your child had: ☐ Hives ☐ Eczema ☐ Sinus Infections/Problems
☐ Hay Fever ☐ Frequent Colds ☐ Frequent Bronchitis

Can your child fully participate without restriction in a camp program designed for children with asthma and diabetes? ☐ YES ☐ NO (If **NO**, please explain)

Limitations in activity: _____

_____

How many times in the past year has your child been to the ER for asthma or diabetes? _____

Has your child been recently exposed to a contagious disease (chicken pox, measles, etc.)?

☐ YES ☐ NO

If **YES**, what disease and when? _____

Please list any other medical or emotional concerns 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 or diabetes for camp staff?

_____

_____

_____

Is your child in need of financial assistance to attend camp? ☐ YES ☐ NO

Asthma Campers Only:

Does your child use peak flow rates? ☐ YES ☐ NO

If **YES**, what is your child's usual peak flow reading? _____

What medications do you give for acute asthma attacks?

Medication	**Dose**	**How Given**
1. _____		
2. _____		
3. _____		

Does your child wheeze year-round? ☐ YES ☐ NO

If **YES**, what makes your child wheeze? _____

Does your child wheeze certain months only? ☐ YES ☐ NO

If **YES**, which months? _____

What are the **first symptoms** your child has when an asthma attack begins?

☐ Cough ☐ Chest tightness ☐ Wheezing ☐ Runny nose

Other symptoms: _____

Has your child been hospitalized for asthma during the past year? ☐ YES ☐ NO

If **YES**, any ICU admissions? ☐ YES ☐ NO Dates: _____

Has your child ever required ventilator support for asthma? ☐ YES ☐ NO

Any intubations? ☐ YES ☐ NO

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Asthma Camp: Physician Form

Name of patient: _____
(First) (Middle) (Last)

Date of birth: _____/_____/_____

1. Is patient under regular medical care? ☐ YES ☐ NO

2. How long has patient had asthma? _____

3. Diagnosis: _____

4. Please list medications routinely required by patient:

Medication	**Dose**	**Time Given**

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

Medication	**Dose**	**Time Given**

6. Have systemic corticosteroids (prednisone, etc.) been required for control during the past year?
☐ YES ☐ NO
If **YES**, give approximate dose and length of treatment: _____

7. Does patient have a peak flow based asthma management plan? ☐ YES ☐ NO
*If **YES**, please attach a copy.

8. Does patient have a peak flow meter? ☐ YES ☐ NO
If **YES**, what is patient's personal best peak flow rate? _____

9. Does patient have a history of recurrent sinusitis? ☐ YES ☐ NO

10. Can patient take Penicillin? ☐ YES ☐ NO Sulfa? ☐ YES ☐ NO
Cephalosporins? ☐ YES ☐ NO Macrolides? ☐ YES ☐ NO

Please continue to next page ⟶

11. Has patient used a bronchodilator by metered dose inhaler in the past year? ☐ YES ☐ NO

12. Is the patient able to participate in regular physical education? ☐ YES ☐ NO

If **NO**, what activities should be avoided? _____

_____

Physician's Signature: _____ Date: _____

Printed Physician's Name: _____

Address: _____

_____

City State Zip

Phone number: _____

Please fax form to Health*Finders*: 843.839.9932