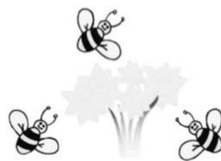
June 13-15, 2019
Healthpark



Allergy & Asthma Specialists, P.S.C.
www.owensboroallergy.com

Dear Parent:

2018 Camp Wheeze Away is almost here, **June 13-15**, at the Healthpark on Ford Avenue. The mission of the Camp is to provide support and education to children ages 6-10 who are diagnosed with asthma. This free Camp allows participants to experience normal activities in a fun, medically supervised manner, while learning more about asthma. **Once we receive your child's application, he/she will be enrolled in the camp. We will not be sending out any additional notifications.**

Your child will be assigned to a group of children of the same age and supervised by volunteers who will help them with activities. The ratio of volunteers to children is 1:5. The volunteers are medical staff, respiratory staff, and community volunteers.

During the first two days of Camp, we will provide a morning snack and lunch. Camp hours are 8:00 a.m. to 3:00 p.m., Thursday and Friday. Saturday's hours are 9:00 to noon. Parents and/or legal guardians are also strongly encouraged to attend Camp on Saturday: We will conduct an education session designed for parents while campers enjoy more activities; lunch will be catered at 11:00 a.m.; and, participants will receive their "goody bags".

Attached are several forms that must be completed and returned to us by **Monday, June 10th, by 4:00 p.m.** Turn in the completed forms to the Membership Front Desk at the Healthpark on Ford Avenue, or mailed to Healthpark ATTN: Melinda Cornell, 1006 Ford Ave., Owensboro, KY 42301. This information will assist us in providing a safe camp environment. You may also drop off forms at Allergy & Asthma Specialists.

We are delighted that your child will be part of this FREE asthma camp for children ages 6-10. Please do not hesitate to call my office if you have any additional questions: (270) 684-6144 or toll free at (877) 291-6303.

Sincerely,

Lee S. Clore, Jr., M.D. Medical Director

SCREENING &
ASSESSMENT FORM

(Must be completed by parent or guardian.)

Instructions: Complete this form for each child applying to attend Camp Wheeze Away. Return to the Healthpark, Health Resource Center, ATTN: Melinda Cornell, 1006 Ford Avenue, Owensboro KY 42301. Return by June 10, 2019.

Child's Name ____

(Last) (First) (Middle)

Prefers to be called ______________________________________

Child's Date of Birth _______________ Grade in school in Fall 2019 ____

Sex: Male or Female Age ______ Weight _____ Height ______

Address: ____

(Street) (City) (State) (Zip)

In Case of an Emergency, Contact:

Parent/Guardian _______________________________Phone _________

Other ______________________________________ Phone _________

Child's Physician ______________________________Phone _________

History of Asthma

How long has your child had asthma?_____________________________

What are his/her "triggers"? ___________________________________

Approximately how many asthma attacks has your child had in the past 12 months? _________

How many times did these asthma attacks require:

Physician Office Visits _____Emergency Room Visits _____

Hospitalization _____

When was your child's most recent hospitalization? Date: ____________

Has your child ever experienced a respiratory arrest or been placed on a ventilator? Yes_____ No _____ If yes, summarize details on a separate sheet of paper.

How many days of school has your child missed in the last 6 months due to his asthma? None _____ 1 to 5 _____ 6 to 10_____ more than 10 ____

How much does your child's asthma interfere with activity or sleep?

What are your child's "Early Warning Signs"? (Check all that apply.)

Watery eyes		Feels "spacey"	
Scratchy throat		Dry mouth	
Runny nose		Gets nervous	
Sneezing		Gets tired	
Heart beats faster		Feels grumpy	
Coughs			

Other (please specify) ____

ALLERGIES:

Is your child allergic to any foods? Yes _____ No _____

If so, please list: ____

Describe reaction: ____

Any other allergies? ____

Latex allergies? ___________________ Bee Stings? _________________

Does your child have an Epipen? Yes _____ No _____

MEDICATIONS:

What medications does your child take on a regular basis?

Medication Name Dosage Times Given

1. ____
2. ____
3. ____

If your child requires any medication during his stay at Camp Wheeze Away, please give the medication to one of the Camp Coordinators each morning before Camp begins. The medicine should be kept in its labeled prescription container. **Do Not forget to send your child's emergency medications!** Thank you.

What medication does your child normally take for acute attacks?

____

Who is responsible for giving the medication when your child is at home?

____

Does your child know the names of his medications? Yes ___ No ____

Does your child know what time to take them? Yes _____ No _____

Does your child know how they work? Yes _____ No _____

Does your child take steroids, such as Prednisone, etc.? Yes ___ No ___

Oral _____ Inhaled _____

Does your child use an inhaler? Yes _____ No _____

Independently? (ie: at school) Yes _____ No _____ Non-applicable _____

ADDITIONAL INFORMATION:

Have you or your child attended classes or educational programs about asthma? Yes ___ No ___ If yes, when and where?

____

Has your child attended a camp for children with asthma in the past?

Yes ___ No ___ If yes, when and where?____________________________

What information would you like to have that will help you or your child better manage his asthma? ______________________________________

____

Does your child have any other illnesses? Yes _____ No _____ If yes, please explain: ____

Does your child have any physical limitations? Yes _____ No _____ If yes,

please explain: ____

Has your child ever had swimming lessons? Yes ___ Where? ___________

When?_________ No _____

Does your child know how to swim? Yes _____ No _____

How would you rate your child's ability to swim?

Good _____ Average _____Poor _____Unable to swim _____

Afraid of water _____

CODE OF CONDUCT:

Our goal is to provide a safe, informative, fun camping experience for every child. All campers are expected to behave in a safe, respectful manner and participate in all activities. If your child is disrespectful, or willfully disobeys instructions or behaves in an unsafe or disruptive manner; then, we will contact you to come to the Camp immediately and remove your child from the premises.

Due to the nature of food allergies, your child will not be allowed to bring any outside food or beverages to camp. If your child does have any outside food or beverage, we will contact you and we will dismiss him/her immediately. Your child will not be allowed to return to camp. We apologize for any inconvenience this may cause, but food allergies can be fatal to some of our participants.

Camp Wheeze Away is not responsible for any lost or stolen items.

I (parent/legal guardian) acknowledge that I have read and fully understand and will abide by the policies and expectations outlined in this registration packet.

Signature of Parent/Legal Guardian:______________________________Date: ______

PHOTO RELEASE

I hereby grant Camp Wheeze Away permission to use my likeness in a photograph or video in any and all of its publications, including website entries, without payment or any other consideration.

I understand and agree that these materials will become the property of Camp Wheeze Away and will not be returned.

I hereby irrevocably authorize Camp Wheeze Away to edit, alter, copy, exhibit, publish or distribute this photo for purposes of publicizing Camp Wheeze Away 's programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph.

I hereby hold harmless and release and forever discharge Camp Wheeze Away from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

Signature of Parent/Legal Guardian:______________________________Date: ______

PHOTOGRAPHY/VIDEOGRAPHY AND INTERVIEW AUTHORIZATION AND RELEASE (PATIENT)

Copy of this form will be provided at check in on June 14, 2019.

For good and valuable consideration herein acknowledged as received, I, the undersigned, hereby authorize ______________________________ and Owensboro Health, Inc. ("Owensboro Health") and any of their affiliates, employees, advertisers, and representative(s) (collectively "PHOTOGRAPHER"), the absolute right and permission to take photographs of and/or to make video or audio recordings of me without further compensation, as well as to interview me and take notes about my comments without compensation to me. Images that may be taken include full images (head to toe), or partial images, including pictures of my face. I hereby irrevocably grant to PHOTOGRAPHER the unrestricted right to use and reproduce my name, image, and voice and any comments I may have made (including summaries thereof) including any and all photographic images and video or audio recordings made by or on behalf of the PHOTOGRAPHER in any medium, including posting on the Internet and the World Wide Web for promotional, marketing, advertising or any other purpose of PHOTOGRAPHER in perpetuity without compensation. I agree that all intellectual property rights to the above-mentioned sound, still or moving images and to any articles written about me are the property of PHOTOGRAPHER. I voluntarily waive the right to inspect or approve such images, recordings or articles about me and waive the right to any royalties, proceeds or other benefits derived from such images, recordings or articles.

I further understand that:

1. Owensboro Health, Owensboro Health Medical Group, Inc., Owensboro Medical Center Laboratory, Inc., and OMHS Cardiovascular, LLC (collectively, the "Affiliated Entities") are affiliated for purposes of complying with the privacy and security provisions of the federal Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA"), and this Authorization allows any of them to use and reproduce my name, image, and voice, and/or to write articles about me, in any medium as described above.

2. I have the right at any time to request that PHOTOGRAPHER stop any photography/recordings/interviews.

3. I have the right to revoke this Authorization in writing at any time and, if I decide to do so, I must present my written revocation to the Director of Health Information Management, Owensboro Health, 1201 Pleasant Valley Rd., Owensboro, KY 42303. A revocation shall not affect any release of information made prior to such revocation in reliance upon this Authorization.

4. I may refuse to sign this Authorization and Release. Such refusal will not affect the medical treatment I receive from any of the Affiliated Entities or any of their employees or credentialed health care providers.

[CONTINUED ON NEXT PAGE]

5. The information disclosed under this Authorization and Release is protected by HIPAA. Any disclosure of information carries with it the potential for an unauthorized redisclosure. Therefore, the information disclosed may not be protected by applicable federal and other confidentiality rules.

6. A copy of this Authorization and Release is valid as the original.

I hereby hold harmless, release, and forever discharge PHOTOGRAPHER from any claims, demands, or causes of action which I, my heirs, representatives, agents, successors or assigns have or may have by reason of this Authorization and Release.

This Authorization and Release is made in the interest of public education and to assist the Affiliated Entities in their marketing efforts. **I certify that I have read this Authorization and Release carefully and fully understand its terms.**

This Authorization shall expire fifty (50) years from its date.

____ ________________________
(Signature of patient or patient's personal representative) Date signed

____
(Printed name of patient or patient's personal representative)

____
If a personal representative signs for the patient, describe the personal representative's authority to do so

PATIENT MUST RECEIVE A SIGNED COPY; IF PATIENT'S PERSONAL REPRESENTATIVE SIGNS, INDICATE THE AUTHORITY HE/SHE HAS TO SIGN FOR THE PATIENT

PLEASE KEEP THIS SHEET FOR YOUR RECORDS.

MISCELLANEOUS INFORMATION

- Camp is June 13-15 (Thursday – Saturday), 2019.
- Camp Hours for Thursday and Friday are 8:00 a.m. to 3:00 p.m.
- Sign in will begin at 8:00 am on Thursday and Friday and 9:00 am on Saturday.
- A morning snack, lunch and afternoon snack will be provided on Thursday and Friday.
- Camp Hours for Saturday are 9:00 a.m. to noon. Lunch will be served at 11:00 a.m. to campers and parents/guardians.
- On Thursday and Friday, campers will be swimming. Please send proper swimming attire, towel, and plastic bag for wet suits. **Please send an extra pair of dry clothes.** Do not send swimming accessories, such as fins, beach balls, or other water toys.
- Campers should wear comfortable athletic shoes.
- Children should not bring games or toys to the Camp, such as playing cards, video games, stereos, radios, head sets, etc. Items such as these will be retrieved by a Camp Coordinator.
- Campers should use caution when wearing jewelry. Jewelry may be lost or stolen.
- Camp Wheeze Away is not responsible for any lost or stolen items.

Please direct questions to the office of

Dr. Lee Clore at

(270) 684-6144, toll free at (877) 291-6303 or email

allergy@cloremd.com.