



Dear Parents:

What if there was a way that your child could learn the skills necessary to successfully handle their asthma so they would never again be victim to their condition? Salinas Valley Memorial Healthcare System (SVMHS) is inviting your child to do just that by attending the 34th Annual Asthma Camp. It is the only summer camp in Monterey County solely designed to educate your child about the disease of Asthma and to do so in an informational and fun environment.

We believe the benefits of this Healthcare System-sponsored program will be immediate and obvious to you. The five daily educational sessions are structured around our own workbook, which includes a complete explanation of education topics, camp activities, and a section for parent education. This program has been highly successful with children and will result in a better understanding of asthma, and an increased ability to cope with its inconveniences and maintain a quality level of daily activity.

We are grateful for support from our SVMHS physicians and Children's Miracle Network for helping make this program available. You are commended for your interest in this educational opportunity for your child. For more information, please visit svmh.com/asthmacamp or call 831-759-1890.

We look forward to an exciting celebration of our 34th Asthma Camp, and we hope your child will be able to join us!

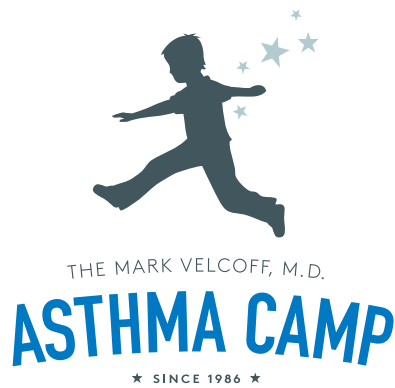
Sincerely,

Pete Delgado
Salinas Valley Memorial Healthcare System
President/CEO

 Salinas Valley Memorial Healthcare System



svmh.com/asthmacamp



Enclosed is an application packet for Asthma Camp 2019 to be held July 22 through July 26, 2019.

- Asthma Camp Information Sheet
- Registration Forms to be completed and returned
- Physician Referral Form to be completed BY PHYSICIAN and returned
- Asthma Control Test Form to be completed and returned
- Waiver and Release Form to be completed and returned
- Emergency Contact Card to be completed and returned
- Map to Monterey Park Elementary School
- Family Luncheon and Graduation Ceremonies Invitation

Space is limited. It is important that your application be returned promptly in order to reserve your child's place at Camp. The physician referral may be returned at a later date due to doctor availability, but must be turned in by the pre-camp meeting.

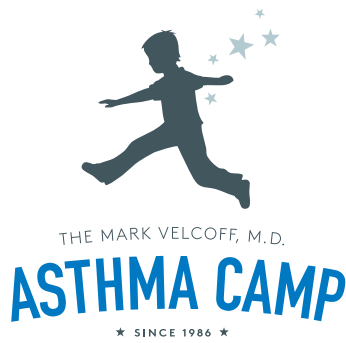
REGISTRATION DEADLINE IS JULY 15, 2019.

Written acknowledgment of your application and fee payment will be sent to you.

 Salinas Valley Memorial Healthcare System



svmh.com/asthmacamp



Dates: July 22 - July 26, 2019

Ages: 6-12 years old

Time Schedule:

Monday: 9:00 am to 4:00 pm
Tuesday: 9:00 am to 4:30 pm
Wednesday (overnight): 9:00 am start
Thursday: 8:00 am to 4:00 pm
Friday: 9:00 am to 1:00 pm

Transportation to and from camp is the responsibility of the parents. For parent convenience child care is available before and after camp, starting at 7:00am and ending at 5:30pm.

Location:

Monterey Park Elementary School, 410 San Miguel Avenue, Salinas
Children will be transported by shuttle bus to off-site activities.

Fee: A \$55.00 registration fee covers the entire five day program. (Scholarships are available. If you'd like to be considered for a scholarship, please contact Chatterbox PR at 831-747-7455 or marci@chatterboxpublicrelations.com)

Payment can be made two ways:

- 1) With credit card through our website
- 2) With check, made payable to: Salinas Valley Memorial Healthcare System
Please note "Asthma Camp" in memo section

Submit completed registration packet on-line at svmh.com/asthmacamp or mail to the address below:

Asthma Camp Registration
SVMHS/Health Promotion Department
450 E. Romie Lane, Salinas, CA 93901

For further information:

Visit svmh.com/asthmacamp or call 831-759-1890.

Medical supervision will be available at Camp. More information to follow.



INFORMATION WILL BE SHARED WITH CAMP COUNSELORS AND VOLUNTEERS AS NEEDED.

Please fill in all blanks and check the appropriate answers.

Name of Child	Date of Birth	Age
<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
Grade		
Address	City	Zip
Parent/guardian	Primary/cell phone #	Email address
Parent/guardian	Primary/cell phone #	Email address

CHILD RELEASE AUTHORIZATION List all persons authorized to pick up your child:

Name	Relationship	Phone #
Name	Relationship	Phone #
Is there anyone not allowed to pick up or contact your child?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Name:		
Will your child be requiring pre-camp child care, starting at 7am?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Will your child be requiring post-camp child care, until 5:30pm?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Does your child have special medical care needs or considerations?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

SELECT ONE

SHIRT SIZE FOR YOUR CHILD:

Child M Child L Adult M Adult L Adult XL Adult XXL

Child's nickname: _____

1. At what age did your child first develop asthma (wheezing)? _____

2. Does anyone else in the immediate family have asthma? Yes No If yes, who? _____

registration form



registration form

3. What triggers your child's wheezing? Please check all that apply.

- Infections
 Animals
 Dust
 Pollens
 Mold
 Emotions
 Exercise
 Foods

List other items: _____

4. Does your child wheeze throughout the year, or only during certain months? _____

5. How many asthma attacks has your child had in the last two months? _____

6. How many days of school did your child miss this past year due to Asthma or breathing difficulties?

7. Is your child in a restricted P.E. class? Yes No _____

8. Has your child ever been hospitalized because of asthma? Yes No _____

9. Number of hospitalizations in past two years: _____ Last admission date: _____

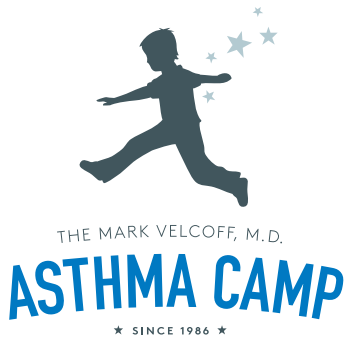
10. How would you describe your child's symptoms? Present only with exercise
 Present but does not interfere with daily activities Present and intermittently interferes with activities and sleep Other, explain: _____

11. Please list all medications your child is taking at this present time:

Name	Strength	Times Given

12. Where did you hear about Asthma Camp? (Please check all that apply.)

- Physician
 Television/Radio/Print
 School
 Other: _____



physician referral

Name of Child

Date of Birth

1. Does this child have Asthma? Yes No

2. Please list child's asthma RESCUE medications: _____

3. Please list child's asthma CONTROLLER medications: _____ None

4. List asthma medications taken just prior to exercise: _____ None

5. List all other medications taken by child: _____ None

6. List asthma triggers (e.g. upper respiratory infections, exercise, pollen, pets, dust, weather):

7. List all allergies (e.g. medications, foods, insect stings, etc.): _____ None

8. Other health issues, disabilities or concerns: _____ None

9. Height: _____ Weight: _____

10. Additional comments: _____

Physician Signature

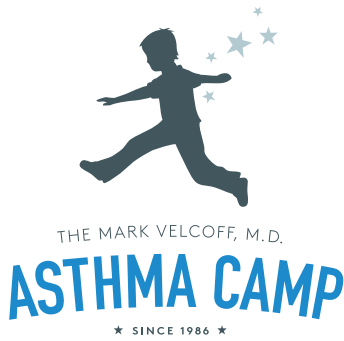
Date

Please return form by mail or fax to:

Asthma Camp Registration, SVMHS/Health Promotion Dept., 450 E. Romie Lane, Salinas, CA 93901

Fax: 831-759-3073

svmh.com/asthmacamp



RELEASE, WAIVER & CONSENT AGREEMENT

___ I give permission for my child to attend The Mark Velcoff, M.D. Asthma Camp at Monterey Park Elementary School in Salinas and to participate in all Asthma Camp activities and field trips. In consideration of my child's participation in The Mark Velcoff, M.D. Asthma Camp, including but not limited to participation in athletic activities, exercise classes, and sports programs including any off-site programs, I understand that Salinas Valley Memorial Healthcare System assumes no responsibility for injuries or illness that my child may sustain as a result of my child's physical condition or resulting from my child's participation in any of the foregoing activities. I give permission to have my child transported from the basic camp activities for any special camp related activities.

___ In the event of my child's illness or injury, I authorize and consent to any x-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care as determined to be necessary and is provided by medical or emergency room staff licensed under the provision of the Medical Practice Act. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide consent to such care when hospital medical personnel deem such care advisable.

___ I understand that the hospital shall attempt to contact me prior to rendering treatment to my child. However, treatment will not be withheld if I cannot be reached. I authorize the hospital to surrender physical custody of my child to the individual who presented him/her for treatment upon completion of the treatment if I am not present on my child's release. This consent shall remain in effect from July 22, 2019 through July 26, 2019.

___ I personally and on behalf of my child do hereby release, discharge and agree to hold harmless Salinas Valley Memorial Healthcare System, its directors, officers, employees, agents and volunteers ("Released Parties") from and against any and all claims or rights which may hereafter accrue against Released Parties for direct or indirect injury, illness, death, loss or damage that I or my child may sustain or suffer as a result of my child's participation in The Mark Velcoff, M.D. Asthma Camp.

___ I also consent to and authorize Salinas Valley Memorial Healthcare System to photograph or permit other persons to photograph my child and use the negatives or prints prepared from such photographs for such purposes as the Salinas Valley Memorial Healthcare System may deem appropriate. I hereby waive any right to compensation for such uses. The term "photograph" shall mean motion picture or still photography in any format, as well as videotape, video disc, and any other mechanical means of recording and reproducing images.

___ I agree that this Release, Waiver and Consent Agreement is intended to be as broad and inclusive as is permitted by the laws of the State of California and that if any portion is held invalid, the balance shall continue in full legal force and effect.

My child will be requiring pre-camp child care, starting at 7am: YES NO

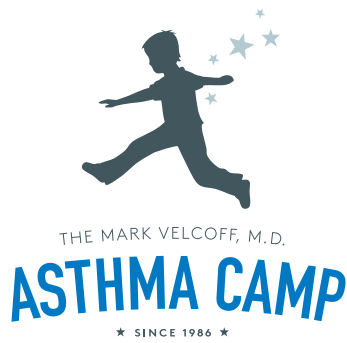
My child will be requiring post-camp child care, until 5:30pm: YES NO

Name of Camper Date

Parent/Guardian Name (Please Print)

Parent/Guardian Signature

waiver & release



You and your family are invited to attend
Salinas Valley Memorial Healthcare System's

34th Annual Mark Velcoff, MD Asthma Camp 2019 Friends and Family Luncheon

The festivities will begin at 11:00 am on Friday, July 26th
It will be held at Monterey Park Elementary School,
410 San Miguel Avenue, Salinas
Look for our camp sign
RSVP by Monday, July 22 to 831-759-1890

The staff of Asthma Camp look forward to
your participation in our final ceremonies.
Help us applaud our special young graduates!

*Please note: Your child will need to be picked up at
Monterey Park Elementary School at 1:00pm, Friday, July 26th.*

*(No post camp care will be available on Friday afternoon.
Please plan accordingly.)*

 Salinas Valley Memorial Healthcare System



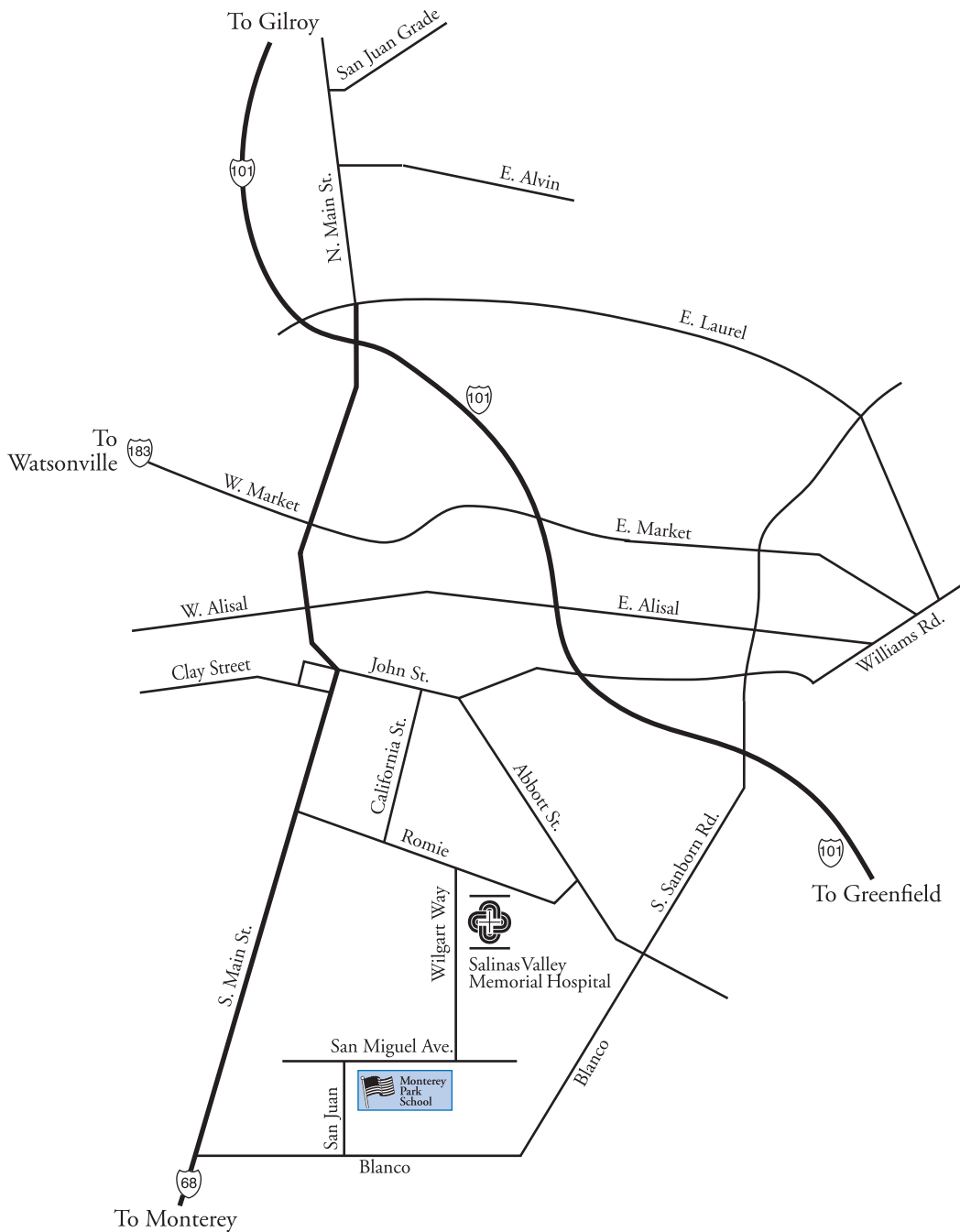
svmh.com/asthmacamp

family graduation



THE MARK VELCOFF, M.D.
ASTHMA CAMP
★ SINCE 1986 ★

Monterey Park Elementary School • 410 San Miguel Avenue, Salinas
Please park in front of school. Walk your child back behind school following the driveway.
Look for Asthma Camp signs.



svmh.com/asthmacamp

directions / map

Enter Name _____

Today's Date: _____

Enter Address _____

Patient's Name: _____

Enter City/State/Zip _____

Childhood Asthma Control Test for children 4 to 11 years.

This test will provide a score that may help the doctor determine if your child's asthma treatment plan is working or if it might be time for a change.

How to take the Childhood Asthma Control Test

Step 1 Let your child respond to **the first four questions (1 to 4)**. If your child needs help reading or understanding the question, you may help, but let your child select the response. Complete the remaining **three questions (5 to 7)** on your own and without letting your child's response influence your answers. There are no right or wrong answers.

Step 2 Write the number of each answer in the score box provided.

Step 3 Add up each score box for the total.





Step 4 Take the test to the doctor to talk about your child's total score.

**19
or less**


If your child's score is 19 or less, it may be a sign that your child's asthma is not controlled as well as it could be. Bring this test to the doctor to talk about the results.

Have your child complete these questions.





1. How is your asthma today?

 0 Very bad	 1 Bad	 2 Good	 3 Very good
---	--	---	--





2. How much of a problem is your asthma when you run, exercise or play sports?

 0 It's a big problem, I can't do what I want to do.	 1 It's a problem and I don't like it.	 2 It's a little problem but it's okay.	 3 It's not a problem.
---	---	--	---

3. Do you cough because of your asthma?

 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.
--	---	---	--

4. Do you wake up during the night because of your asthma?

 0 Yes, all of the time.	 1 Yes, most of the time.	 2 Yes, some of the time.	 3 No, none of the time.
--	---	---	--

Please complete the following questions on your own.

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
------------------------	----------------------	-----------------------	------------------------	------------------------	----------------------

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
------------------------	----------------------	-----------------------	------------------------	------------------------	----------------------

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

5 Not at all	4 1-3 days	3 4-10 days	2 11-18 days	1 19-24 days	0 Everyday
------------------------	----------------------	-----------------------	------------------------	------------------------	----------------------

SCORE

TOTAL

CHILD'S NAME _____ DATE OF BIRTH _____ AGE _____ MALE FEMALE

NAME OF PARENT(S) _____

HOME PHONE _____ WORK PHONE _____ WIRELESS PHONE _____

ADDRESS _____

EMERGENCY INFORMATION: LIST ALTERNATE PERSONS TO CALL IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

PHYSICIAN _____ PHONE _____

HAVE YOU ATTENDED CAMP PREVIOUSLY? YES NO YEARS _____

PRESENT MEDICATIONS _____

SEVERE ALLERGIES _____ *Please write any additional comments on the back side of this card.*

