



933 Friendly Pines Road
Prescott, AZ 86303

Camper Asthma Action Plan

for campers who have asthma or who have ever experienced
asthma-like symptoms
(Return with blue medical form, if applicable)

Name of Camper _____

Age _____ Date of Birth _____ Grade Next Fall _____

Asthma Care Physician _____ Phone Number _____

Other Physician _____ Phone Number _____

When my child is nearing an asthma episode, I notice the following signs (please circle all that apply):

- | | | | |
|------------------------|--------------|---------------|---------------------------------------|
| Runny/Stuffy Nose | Tummy Ache | Getting Upset | Coughing |
| Funny Feeling in Chest | Feeling Weak | Nervous | Watery eyes |
| Itchy Throat | Headache | Sad | Circle under eyes |
| Itchy Chest | Dry Mouth | Sneezing | Other (please list on separate paper) |

My child's asthma triggers (things that start an asthma attack) are (please circle all that apply):

- | | | | |
|------------------|-----------|--------------------------------|-----------------------|
| Animals with Fur | Smoke | Sinus Infections | Emotions (Sad, Happy) |
| Dust | Cold Air | Exercise (Running, Sports) | Cockroaches |
| Cigarette Smoke | Humid Air | Aerosols (Hair Spray, Perfume) | Mold |
| Strong Smells | Colds | | |

Food (please list): _____

Other (please list): _____

I have reviewed my child's action plan with my child's asthma care physician and believe all of the information to be accurate. I agree to notify the Camp Medical Staff of any changes in my child's condition including emergency room visits and hospitalizations. I give the Friendly Pines Camp staff and its physician permission to contact one another or my insurance/Medicaid carrier for the purpose of obtaining information related to my child's health. A reasonable effort will be made to obtain the information from me prior to any other source.

Parent/Guardian Signature _____ Date _____

Please have your physician complete the 2nd side (over).

Asthma Action Plan

To be completed by physician

Possible Warning Signs	Child's Height Peak Flow Zones	Child's Weight Treatment Plan									
<p style="text-align: center;"><u>ALL CLEAR!</u></p> <ul style="list-style-type: none"> • sleeping without symptoms • able to do normal activities w/out symptoms <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • peak flow 80 or 100% of predicted or personal best <p>Camper's personal best peak flow meter reading is _____.</p> <p style="text-align: center;">OR</p> <p>Camper's predicted peak flow meter reading is: _____.</p>	<p>GREEN ALL CLEAR!</p> <p>_____ To _____.</p> <p>Greater than 80% of Best of Predicted Peak Flow</p>	<p>Long-term Control – Daily Meds</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Medicine</td> <td style="width: 33%;">How Much</td> <td style="width: 33%;">Frequency</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table> <p>Before exercise: Take <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs of _____.</p> <p>_____ minutes before exercise.</p>	Medicine	How Much	Frequency	_____	_____	_____	_____	_____	_____
Medicine	How Much	Frequency									
_____	_____	_____									
_____	_____	_____									
<p style="text-align: center;">BE CAREFUL!</p> <p>Early warning signs of asthma may be seen:</p> <ul style="list-style-type: none"> • cold symptoms and/or fever • coughing/wheezing but able to do normal activities • shortness of breath with activity • chest tightness • waking at night with cough/wheeze <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • peak flow 50 to 80% of personal best 	<p>YELLOW CAUTION!</p> <p>_____ To _____.</p> <p>50-80% of Best of Predicted Peak Flow This is NOT where camper should be every day.</p> <p style="text-align: center;">TAKE ACTION</p>	<p style="text-align: center;">QUICK RELIEF – for Mild/Moderate Symptoms</p> <p>First Medicine: _____.</p> <p>Take <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> by nebulizer one time</p> <p>Then: If improvement in 15 minutes: _____.</p> <p>_____.</p> <p>If no improvement in 15 minutes: _____.</p> <p>_____.</p>									
<p style="text-align: center;">DANGER!</p> <p>This is an emergency; you need help!</p> <ol style="list-style-type: none"> 1. difficulty walking or talking 2. uses neck/stomach muscles when breathing 3. needs rescue medication more frequently than every 4 hours 4. constant coughing 5. worsening symptoms after treatments 6. blue or gray lips or fingernails <p style="text-align: center;">OR</p> <ol style="list-style-type: none"> 7. peak flow less than 50% of personal best. 	<p>RED DANGER!</p> <p>Below _____.</p> <p>Less than 50% of Best of Predicted Peak Flow</p>	<p>ALERT – For Severe Symptoms</p> <p>First, take this medicine: _____.</p> <p>Take <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> by nebulizer one time</p> <p>If feeling better or repeat peak flow is in yellow zone, call doctor and ask for further instructions</p> <p>If no improvement or repeat peak flow is in red zone or nails or lips are blue or breathing is difficult: GO TO THE EMERGENCY ROOM OR CALL 911!!</p>									

Physician Signature _____ Date _____

(Print and Sign)

Address _____

Phone _____