SUMMER 2022

CAMPER ASTHMA ACTION PLAN

****This form is only necessary for campers who have asthma or who have ever experienced asthma-like symptoms.*

PARENTS/GUARDIANS: PLEASE FILL OUT THE FIRST PAGE OF THIS FORM, THEN HAVE YOUR CAMPER'S PHYSICIAN COMPLETE THE SECOND PAGE. RETURN BOTH PAGES TO MEDICAL@FRIENDLYPINES.COM

CAMPER'S FIRST & LAST NAME: _____

DATE OF BIRTH: _____ AGE: _____ GRADE NEXT FALL: _____

ASTHMA CARE PHYSICIAN: _____ PHONE #: _____

OTHER PHYSICIAN: _____ PHONE #: _____

When my child is nearing an asthma episode, I notice these 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	Circles under eyes
Itchy chest	Dry mouth	Sneezy	Fatigue

Other signs my child exhibits: _____

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	Aerosols (hair spray, perfume)	Humid air	Mold
Strong smells	Colds		

Food triggers: _____

Other triggers: _____

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: _____

SUMMER 2022

FRIENDLY PINES CAMP Est. 1941

ASTHMA ACTION PLAN

to be completed by Physician

CHILD'S NAME: _____ HEIGHT: _____ WEIGHT: _____

POSSIBLE WARNING SIGNS	PEAK FLOW ZONES	TREATMENT PLAN
ALL CLEAR! • sleeping without symptoms • able to do normal activities w/out symptoms *OR* • peak flow 80 or 100% of predicted or personal best Camper's *personal best* peak flow meter reading is: _____ *OR* Camper's *predicted* peak flow meter reading is: _____	**GREEN ZONE: ALL CLEAR!** _____ to _____ *Greater than 80% of best predicted peak flow*	**LONG-TERM CONTROL:** *(daily meds)* *Medicine Dose Frequency* _____ _____ **BEFORE EXERCISE:** Take ☐ 2 or ☐ 4 puffs of _____ _____ minutes before exercise
BE CAREFUL! Early warning signs of asthma may be seen: • cold symptoms and/or fever • coughing/wheezing but able to do normal activities • shortness of breath with activity • chest tightness • waking at night *OR* • peak flow 50-80% of personal best	**YELLOW ZONE: CAUTION!** _____ to _____ *50-80% of best and/or predicted peak flow* *This is NOT where camper should be every day.* TAKE ACTION	**QUICK RELIEF:** *(for mild/moderate symptoms)* First Medicine: _____ Take ☐ 2 or ☐ 4 puffs or ☐ by nebulizer one time Then: _____ If improvement in 15 min: _____ _____ If NO improvement in 15min: _____ _____
DANGER! This is an emergency; you need help! • difficulty walking or talking • uses neck/stomach muscles when breathing • needs rescue medication more frequently than every 4 hours • constant coughing • worsening symptoms after treatments • blue or gray lips or fingernails *OR* • peak flow less than 50% of personal best	**RED ZONE: DANGER!** _____ to _____ *less than 50% of best and/or predicted peak flow*	**ALERT:** *(for severe symptoms)* First, take this medication: Take ☐ 2 or ☐ 4 puffs or ☐ by nebulizer one time If feeling better or repeat peak flow is in yellow zone, call doctor and ask for further instructions. If no improvement or repeat peak flow in red zone or nails/lips are blue or breathing is difficult GO TO THE EMERGENCY ROOM OR CALL 911!

Physician Signature: _____ Date: _____

(print & sign)

Address: _____

Phone Number: _____