



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: _____



ASTHMA ACTION PLAN

to be completed by Physician

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

POSSIBLE WARNING SIGNS	PEAK FLOW ZONES	TREATMENT PLAN
<p>ALL CLEAR!</p> <ul style="list-style-type: none"> • sleeping without symptoms • able to do normal activities w/out symptoms <p style="text-align: center;"><i>OR</i></p> <ul style="list-style-type: none"> • peak flow 80 or 100% of predicted or personal best <p>Camper's <i>personal best</i> peak flow meter reading is:</p> <p>_____</p> <p style="text-align: center;"><i>OR</i></p> <p>Camper's <i>predicted</i> peak flow meter reading is:</p> <p>_____</p>	<p>GREEN ZONE: ALL CLEAR!</p> <p>_____ to _____</p> <p><i>Greater than 80% of best predicted peak flow</i></p>	<p>LONG-TERM CONTROL: <i>(daily meds)</i></p> <p>Medicine Dose Frequency</p> <p>_____</p> <p>_____</p> <p>BEFORE EXERCISE: Take <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs of</p> <p>_____</p> <p>_____ minutes before exercise</p>
<p>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 <p style="text-align: center;"><i>OR</i></p> <ul style="list-style-type: none"> • peak flow 50-80% of personal best 	<p>YELLOW ZONE: CAUTION!</p> <p>_____ to _____</p> <p><i>50-80% of best and/or predicted peak flow</i></p> <p><i>This is NOT where camper should be every day.</i></p> <p style="text-align: center;">TAKE ACTION</p>	<p>QUICK RELIEF: <i>(for mild/moderate symptoms)</i></p> <p>First Medicine:</p> <p>_____</p> <p>Take <input type="checkbox"/> 2 or <input type="checkbox"/> 4 puffs or <input type="checkbox"/> by nebulizer one time</p> <p>Then:</p> <p>_____</p> <p>If improvement in 15 min:</p> <p>_____</p> <p>If NO improvement in 15min:</p> <p>_____</p> <p>_____</p>
<p>DANGER!</p> <p>This is an emergency; you need help!</p> <ul style="list-style-type: none"> • 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 <p style="text-align: center;"><i>OR</i></p> <ul style="list-style-type: none"> • peak flow less than 50% of personal best 	<p>RED ZONE: DANGER!</p> <p>_____ to _____</p> <p><i>less than 50% of best and/or predicted peak flow</i></p>	<p>ALERT: <i>(for severe symptoms)</i></p> <p>First, take this medication:</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 in red zone or nails/lips are blue or breathing is difficult GO TO THE EMERGENCY ROOM OR CALL 911!</p>

Physician Signature: _____ Date: _____
(print & sign)

Address: _____

Phone Number: _____