Kamper Asthma Action Plan

PLEASE COMPLETE THIS FORM ONLY IF YOUR CHILD HAS A SEVERE ASTHMA CONCERN THAT COULD RESULT IN AN ASTHMA ATTACK AT KAMP.

Kamper's Name _____ Age _____

Group Leader _____ Group Name _____

Daily Asthma Management Plan

Please indicate which of the following triggers an Asthma episode for your child: (check all that apply)

□ Exercise □ Strong odors/fumes □ Respiratory infections □ Climate/temperature changes □ Molds

□ Animals □ Chalk/dust □ Carpets □ Pollens □ other _____

If certain foods are a trigger please list them below and complete an allergy action plan for each:

_____

_____

_____

Daily Asthma Medications: Please list those medications your child should use daily to help prevent an asthma episode.

Medication Name	Dosage	When to Use

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Environment Control: Please list any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode. _____

_____

_____

Peak Flow Monitoring: Personal Best Peak Flow number _____

Monitoring Times (please indicate am or pm) _____ _____ _____ _____ _____

Emergency measures will be taken if your child has a Peak Flow reading of_____

Emergency Plan

Emergency action is necessary when the student has symptoms such as the following:

1. _____ 2. _____

3. _____ 4. _____

Emergency Asthma Medications (please list any medications not previously listed either on the Kamper health form or the daily medications list on this form)

Medication Name	Dosage	When to Use

Actions Steps during an Asthma Episode:

1. Check peak flow.
2. Give medications as listed above. Kamper should respond to treatment within 15-20 minutes.
3. Contact parent/guardian if _____
4. Re-check peak flow.
5. Seek emergency medical care if the Kamper has any of the following.
    a. No improvement within 15-20 minutes after initial treatment with medication.
    b. Peak flow is at the level indicated above.
    c. Hard time breathing with:
        i. Chest and neck pulled in with breathing
        ii. Stooped body posture
        iii. Struggling or gasping
    d. Trouble walking or talking
    e. Stops playing and can't start activity again
    f. Lips or fingernails are grey or blue

Comments/Special Instructions: _____

_____

_____

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I certify that the above information is correct to the best of my knowledge and that all medications listed have been sent with my child in quantities to span the entire Kamp visitation period as well as for any emergencies which may arise.

In my opinion, my child □ should be allowed □ should **not** be allowed to carry and use his/her inhaler by him/herself.

Parent/Guardian Signature _____ Date _____

Form adapted from the Asthma and Allergy Foundation of America