Reviewed by camp staff (initial):_____date:_____

Asthma Action Plan for RVR Health Services

If the participant has been diagnosed with asthma and is under the age of 18, this form must be completed and signed by both the physician and the parent or legal guardian.

Name:_____**DOB**_____

Check Asthma Severity:

□ Mild Intermittent □ Mild Persistent
□ Moderate Persistent □ Severe Persistent

Personal Best Peak Flow: _____

******Peak flow meters are mandatory for asthma conditions, unless otherwise ordered by the doctor.******

GO (Green) Peak Flow _____to_____ Use these medications every day.

All of the following must be present:
- Breathing is good.
- No cough/ wheeze.
- Sleeping well.
- Can work and play.

Medicine/Dosage	How much to take	When to take it
For exercise, take:		

CAUTION (Yellow) Peak Flow _____to_____ Continue with Green zone and **add**:

If any of these are present:
- First sign of a cold.
- Exposure to a known trigger.
- Cough**.**
- Mild wheeze.
- Tight chest.
- Cough at night.

If Yellow zone meds are used more than 2-3 times in a week, call the doctor.

Medicine/Dosage	How much to take	When to take it
Comments:		

DANGER (Red) Peak Flow _____to _____ Administer these medicines & **call Dr**.

Asthma is getting worse fast:
- Medicine is not helping within 15-20 mins.
- Difficulty breathing.
- Nose opens wide.
- Ribs show.
- Lips/nails blue.
- Trouble walking/talking.

If doctor can not be reached, go directly to the emergency room. Do Not Wait!

Medicine/Dosage	How much to take	When to take it
Comments:		

Trigger List:

- ❑ Chalk Dust
- ❑ Cigarette smoke
- ❑ Colds/Flu
- ❑ Dust
- ❑ Dust mites
- ❑ Stuffed animals
- ❑ Carpet
- ❑ Exercise
- ❑ Mold
- ❑ Ozone alert days
- ❑ Pests
- ❑ Pets
- ❑ Plants, flowers, cut grass, pollen
- ❑ Strong odors, perfume, cleaning products
- ❑ Sudden temperature change
- ❑ Wood smoke
- ❑ Foods:

_____
_____

- ❑ Other:

_____
_____

Doctor's Signature_____ Date_____

I understand that any child with a chronic health condition is more at risk in a new environment to have changes in their health status. I have been informed that the camp health center is a basic first aid station and NOT equipped for medical emergencies of a catastrophic nature. I know my child has a pre-existing condition and I will fully accept any financial responsibility incurred as a result of a decision by the staff of River Valley Ranch to seek outside medical attention. I agree to allow my child to attend camp with the knowledge I have of my child's condition and the camp setting. I further understand that non-compliance with Doctor's orders and/or camp policies will result in my child's dismissal from camp without refund.

Parent/Guardian Signature:_____ Date:_____

Authorization for Self Administration & Self Carry for emergency inhaler:
(It is the camper's responsibility to report usage to the camp health staff)

This section must be completed in addition to the above for those campers who request permission to carry and self administer their own inhaler.
- We acknowledge that the camper named above has been instructed as to the proper use, understands the purpose and the appropriate method as well as the frequency of use of their inhaler.
- We request that the camper may be able to carry their emergency inhaler on their person or secured in their luggage while at camp.

Doctor's Signature_____ Date: _____

Parent/Guardian Signature_____ Date: _____

Doctor's Stamp