

**LEAVE NO SPACE BLANK
REQUIRED for every camper
with Asthma**

ASTHMA ACTION PLAN

STUDENT'S NAME _____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Please circle student's known asthma triggers: pollens stress anxiety cold air exercise

Allergy (please specify) _____ Other _____

Current medications for asthma control: _____

Asthma medication to be given at camp: _____

Is student capable and responsible for self-administering this medication? Yes No

May student carry inhaler? Yes No

Note: A camp may choose to follow more restrictive procedures regarding student's self-administration.

If an asthma attack occurs at camp, follow these steps:

1. _____

2. _____

3. _____

4. _____

Other special instructions: _____

Health Care Provider Signature: _____

Date: _____

TO BE COMPLETED BY GUARDIAN

I understand that:

- if symptoms are not relieved by steps taken above and indicate the need for emergency care, camp personnel will activate the 911 emergency system.
- if my child does not keep an inhaler in the camp's health office and/or self-administers medication in locations other than the camp health office, it is my responsibility to review with my child when he/she should come to the camp health office for additional medical assistance.
- if I am not available at numbers listed on reverse side, contact:

Name _____

Phone number _____

Additional Comments: _____

Guardian Signature _____

Date _____

TO BE COMPLETED BY CAMP NURSE

Nurse Signature _____

Date received at camp _____

Please complete and return form to: **Great Lakes Science Center**
Attn: Science Camps
601 Erieside Avenue
Cleveland, Ohio 44114