ACTION CARE PLAN: ASTHMA

Student's Name: _____Age: _____ DOB: ____/____/_____

EMERGENCY INFORMATION:

Parent/Guardian Name: _____

Mother: Cell: _____ Work: _____ Home: _____

Father: Cell: _____ Work: _____ Home: _____

Emergency Contact (different from above) Name & Phone: _____

Physician Name: _____ Phone: _____

Physician Address: _____

List any items that trigger student's asthma:

_____

_____

Symptoms student will exhibit during an Asthma Episode:

_____

_____

Name of ALL Current Medication(s): Including: Dosage/Frequency/Times(s):
(Please complete our MANDATORY *Medication Dispensing Form* if medication is to be given during camp):

Medications	Medication Dosage, Frequency/Times(s)

Any additional information:

_____

Quick Guide:

Asthma Emergency Treatment: The following are possible signs of an asthma emergency and need immediate action:

-Difficulty breathing, walking, or talking -Blue/grey discoloration of lips and/or fingernails -Breathing hard/fast

-Failure of medication to reduce symptoms

If these symptoms are observed, take this action immediately:

-Call 9-1-1 -Alert Medical Director -Call a parent/guardian

Signature of Parent/Guardian: _____Date: _____