ASTHMA & ALLERGY CARE PLAN

Camper Name: _____

Session: ___ Full ___ 1 ___ 2

NON-DRUG ALLERGIES

What is your child allergic to?

Allergen	Reaction	When did this happen

What medication(s) does your child take for these allergies? (Please have physician complete Medication Permission Request Form for any prescription medications.)

- ❒ _____ daily all summer to prevent allergy
- ❒ _____ daily, only if child is beginning to have allergic symptoms
- ❒ Benadryl dose _____mg if child is having an acute reaction
- ❒ EpiPen if child is having a severe allergic reaction.

If your child has been prescribed an EpiPen, do they know how to administer it themselves, and do you give consent for them to do so? ____ Yes ____ No

_____ _____

Parent Signature Date

Fax # 603 569-5813

ASTHMA & ALLERGY CARE PLAN

Camper Name: _____

Session: ___ Full ___ 1 ___ 2

ASTHMA

What triggers your child's asthma? _____

_____

Has your child ever been hospitalized for asthma? _____

How often does your child tend to need their rescue inhaler? _____

_____

What is your child's usual goal peak flow measurement? _____

What medication(s) does your child take to control their asthma? (Please have physician complete Medication Permission Request Form for any prescription medications.)

- ❒ _____ daily all summer to prevent asthma symptoms
- ❒ _____ daily, only if child is having a flare-up of asthma symptoms
- ❒ _____ when child is having acute asthma symptoms
- ❒ _____ when child is having severe asthma symptoms

If your child has an Asthma Action Plan, please attach a copy.

_____ _____

Parent Signature Date

Fax # 603 569-5813