

# Asthma Management Plan

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_

## Asthma Classification

- |   |  |
|---|--|
| <input type="checkbox"/> Exercise Induced | <input type="checkbox"/> Moderate Persistent |
| <input type="checkbox"/> Intermittent     | <input type="checkbox"/> Severe Persistent   |
| <input type="checkbox"/> Mild Persistent  |  |

## Asthma Triggers:

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Foods: _____             | <input type="checkbox"/> Smoke        |
| <input type="checkbox"/> Animals Bee/insect sting | <input type="checkbox"/> Pollens      |
| <input type="checkbox"/> Respiratory infections   | <input type="checkbox"/> Molds        |
| <input type="checkbox"/> Dust mites/Dust          | <input type="checkbox"/> Strong odors |
| <input type="checkbox"/> Exercise                 | <input type="checkbox"/> Other _____  |

## Daily Asthma Medications to be taken at summer camp

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Frequency \_\_\_\_\_

Max Doses per day if using SMART therapy: \_\_\_\_\_

## Rescue Asthma Medication:

Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Frequency: \_\_\_\_\_

Indications to start Rescue Inhaler \_\_\_\_\_

Indications to start Daily Asthma Medication if used intermittently:

\_\_\_\_\_

## Permission to Carry/Self Administer:

- I have instructed the patient in the proper way to use their medications. It is my professional opinion that they should carry their asthma/allergy medicine. YMCA Camp Huckins has permission to allow the patient to carry and self administer above medication.
- It is my professional opinion that the patient should **not** carry their asthma/allergy medicines by themselves. Medication will be stored at the health center and administered by Camp Huckins health center staff.

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_