ASTHMA
Individual Treatment Plan

Estes Park Center
YMCA of the Rockies
Youth Programs

Camper Name: ______________________ Date of Birth: _______ Camp Week #:______ Group: ________________________

TRIGGERS: ☐Weather (cold air, wind) ☐Illness ☐Exercise ☐Smoke ☐Dust ☐Pollen ☐Stress ☐Pollen ☐Fatigue
☐Dehydration ☐Respiratory Infection/cold ☐Allergen __________________ ☐Food item ______________________
☐ Other(s):____
☐ **Life threatening allergy** (Specify):____

If there is no quick relief at camp and the camper is experiencing asthma symptoms:

- Call parents/guardians to pick up camper and/or bring inhaler/medications to camp
- Inform them that if they cannot get to camp, 911 may be called

**I give permission for camp staff to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the camp with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.*

_______________________________ ____________________________ __________________ _________
Parent/ Legal Guardian Signature Printed Name Phone Date

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Camper participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: ☐ Not required
Pretreatment for strenuous activity: ☐ Routinely **OR** ☐Upon request Explain: (weather, viral, seasonal, other) ______________________
☐Give 2 puffs of quick relief med (Check one): ☐Albuterol ☐Other:________________________________10-15 minutes before activity.
☐Repeat in 4 hours if needed for additional or ongoing physical activity.
If camper is currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	DO THIS:
• Trouble breathing • Wheezing • Frequent cough • Complains of chest tightness • Not able to do activities but still talking in complete sentences • Peak flow between _________ and __________ • Other:_________________________________	1. Stop physical activity. 2. Give QUICK RELIEF MED: (Check one): ☐Albuterol ☐ Other:_________________________ *Dosage: ☐2 puffs ☐Other:________________ 3. Call parents/guardians and camp nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. ***If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.***

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips or fingernails are gray or blue • ↓ Level of consciousness • Peak flow < _______________________	1. GIVE QUICK RELIEF MED (Check one): ☐Albuterol ☐ Other:_________________________ *Dosage: ☐2 puffs ☐Other:________________ ☐Refer to anaphylaxis plan if camper has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and camp nurse. 4. Encourage camper to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: ☐Albuterol ☐ Other:_________________________ *Dosage: ☐2 puffs ☐Other:________________ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs). **Camp personnel should not drive camper to hospital.*

INSTRUCTIONS for QUICK RELIEF INHALER USE: (Check appropriate boxes)

☐ Camper understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at camp independently with approval from camp nurse.
☐ Camper is to notify his/her designated camp nurse after using inhaler.
☐ Camper needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) ________________.

_______________________________ ________________________ __________________ ____________
Health Care Provider's Signature **Printed Name** **Phone** **Date**

Email this completed form to: daycampepc@ymcarockies.org or Fax to Youth Programs: 970-577-1255
Phone: 970-586-3341, ext. 1280