Pediatric Asthma Action Plan & Summer Camp Clearance

Date: _____

Section 1: Patient Information

Patient Name: _____

Date of Birth: _____

Severity Classification: [ ] Intermittent [ ] Mild Persistent [ ] Moderate Persistent [ ] Severe Persistent

Section 2: Asthma Action Plan

Green Zone: Doing Well (No coughing, wheezing, or chest tightness)

Controller Medication: _____ **Dose:** _____ **Frequency:** _____

Pre-exercise Medication: _____ **Dose:** _____ **Timing:** 15-30 mins before activity

Yellow Zone: Caution (Cough, wheeze, tight chest, or waking at night)

Rescue Medication: _____ **Dose:** _____ **Frequency:** Every 4 hours as needed

Contact parents if symptoms do not improve within 20 minutes of rescue dose.

Red Zone: Medical Alert (Very short of breath, ribs sticking out, medicine not helping)

Immediate Action: Give _____ **Dose:** _____ and **CALL 911 IMMEDIATELY.**

Section 3: Summer Camp Clearance

I examine the above-named patient on _____ and find them to be in satisfactory physical condition to participate in summer camp activities, including physical education and sports.

Self-Carry Authorization:

[ ] This student has been instructed in the proper use of their rescue inhaler and is cleared to self-carry and self-administer this medication.
[ ] This medication must be stored in the camp infirmary/health office.

Section 4: Healthcare Provider Signature

Provider Name: _____

Clinic Name: _____

Phone Number: _____

Signature: _____

Section 5: Parent/Guardian Consent

I approve of this Asthma Action Plan and give permission for camp staff to administer medications as listed above.

Parent Signature: _____ **Date:** _____