

Camp Huntington
PO Box 37,
High Falls, NY 12440

Ph: 866-514-5281
Fax: 845-853-1172

ONLY If your Child Has Asthma

Request for Additional Information About Your Child's Asthma

Camper: _____ Arrival Date: _____

We want your child to receive appropriate care and support for his/her asthma while attending camp. Please complete this in consultation with your physician and return it to the address at the end of the form. Contact [insert name of person] at [insert phone number] with questions or concerns. Please attach additional information as needed, including physician medication orders or greater detail about your child's asthma history.

About our Camp – **[Note: tailor this section to describe your camp's risk profile for people who have asthma. The following statements are provided as an example of what this might be.]**

1. The program takes place in the outdoors. Your camper will be exposed to trees, grasses, dust, pollens, molds, insect bites and a host of other environmental factors.
2. We recommend that campers who use an "as needed" inhaler carry the inhaler with them (on their person). Expect our camp's healthcare provider to place his/her initials on the inhaler(s). This is a visual cue to our staff that your medication needs to be with you.
3. Not all camp programs have an RN in residence. At minimum, a person trained in first aid, CPR and our camp's healthcare plan is available.
4. Our camp has access to a physician, clinic and hospital in our local community. Note that it takes at least [insert number] minutes to transport someone from camp to the next level of health care. Sometimes it may take longer.
5. Our Health Center has injectable epinephrine for emergency use. There is no oxygen tank at camp.
6. Staff are told that children with asthma are capable self-managers and that these campers know when to use their medication or amend activity to compliment their health status.

❖ ABOUT TRIGGERS . . .

- Exercise Fatigue
- Dehydration Stress
- Food Item Smoke
- Allergen _____
- Respiratory infections/common cold
- Other _____

What triggers your child's asthma? Provide details about the triggers, including things which cabin and activity counselors should be told.

❖ USING A PEAK FLOW METER . . .

We recommend using a peak flow meter to monitor your child's status and note signs of a potential flare before it is well established. Please have your child bring his/her peak flow meter.

When does this child do peak flow readings?

- Breakfast Lunch Supper Bedtime
- Other: _____

"Personal Best" peak flow reading for this child (green range): _____

Caution range (yellow) : _____

What should be done if this child's peak flow reading drops to the caution/yellow range?

Danger range (red zone): _____

What should be done if this child's peak flow reading drops to the danger/red zone?

❖ **ABOUT MEDICATIONS . . . [Tailor the wording in this section so it reads correctly for your camp]**

Medications are supervised by our healthcare staff and kept in the health center with the exception of inhalers that must be carried by the person. Medications are usually dispensed at mealtime and brought to the dining room so your camper doesn't have to interrupt his/her activity. While we'd like to use mealtime as much as possible to give routine medications, we can arrange a different time if needed (e.g., mid-morning, mid-afternoon).

These Medications Are Used Daily to Manage This Child's Asthma

Name of Medication	Dose Given	When	Reason for Using this Med

These Medications Are Taken "As Needed" to Prevent an Asthma Flare

Name of Medication	Dose Given	When	Reason for Using this Med

These Medications Are Used When This Child's Asthma Flares

Name of Medication	Dose Given	At What Point Should this be Used?	What Effect Should be Expected & How Quickly?

❖ **NEBULIZER TREATMENT & USE**

Will this child bring a nebulizer to camp? YES NO
 IF YES . . . We expect the child knows when s/he needs a nebulizer treatment and how to use the machine.

What medication is used via nebulizer? _____

Nebulizers are kept in our health center and available when needed by your camper.

❖ **WHEN WE HAVE QUESTIONS, WHO SHOULD WE CONTACT?**

Name: _____ Phone: _____

Name: _____ Phone: _____

❖ **AT WHAT POINT SHOULD WE NOTIFY YOU (Parent, Guardian) ABOUT AN ASTHMA FLARE?**

❖ **AT WHAT POINT SHOULD THIS CHILD BE TAKEN TO A PHYSICIAN OR HOSPITAL?**

Return to:
 Camp Huntington
 PO Box 37
 High Falls, NY 12440

Your Signature and Print Name: _____

Relationship to Child: _____

Date: _____