

**LEAVE NO SPACE BLANK  
REQUIRED for every camper  
with Asthma**



**ASTHMA ACTION PLAN FOR GREAT LAKES SCIENCE CENTER CAMPS**

STUDENT'S NAME \_\_\_\_\_

**TO BE COMPLETED BY HEALTH CARE PROVIDER**

Please circle student's known asthma triggers:    pollens    stress    anxiety    cold air    exercise

Allergy (please specify) \_\_\_\_\_ Other \_\_\_\_\_

Current medications for asthma control: \_\_\_\_\_

Asthma medication to be given at camp: \_\_\_\_\_

Is student capable and responsible for self-administering this medication?    Yes    No

May student carry inhaler?    Yes    No

*Note: A camp may choose to follow more restrictive procedures regarding student's self-administration.*

If an asthma attack occurs at camp, follow these steps:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Other special instructions: \_\_\_\_\_

Health Care Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**TO BE COMPLETED BY GUARDIAN**

I understand that:

- if symptoms are not relieved by steps taken above and indicate the need for emergency care, camp personnel will activate the 911 emergency system.
- if my child does not keep an inhaler in the camp's health office and/or self-administers medication in locations other than the camp health office, it is my responsibility to review with my child when he/she should come to the camp health office for additional medical assistance.
- if I am not available at numbers listed on reverse side, contact:

Name \_\_\_\_\_

Phone number \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**TO BE COMPLETED BY CAMP NURSE**

Nurse Signature \_\_\_\_\_

Date received at camp \_\_\_\_\_

Please complete and return form to: **Great Lakes Science Center  
Attn: Science Camps  
601 Erieside Avenue  
Cleveland, Ohio 44114**