ASTHMA MANAGEMENT PLAN

CHILD'S NAME _____ **AGE** _____

Daily Medication Plan

Name of medication	Amount given	Time given
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Please list any things that you know may **start an asthma episode:**

_____

Please list any **symptoms** that would indicate your child is **having a problem:**

_____

Please list child's **normal peak flow number:** _____

Emergency Procedures

If peak flow number falls below _____, please do the following: _____

List medication, dosage and indication for medication below:

Medication	Dosage	When to use
_____	_____	_____
_____	_____	_____
_____	_____	_____

List medications kept at camp:

_____

Emergency Contacts

Name _____ **Relation to Child** _____ **Phone** _____

Name _____ **Relation to Child** _____ **Phone** _____

Doctor _____ **Phone** _____

Parent/Guardian Signature _____ **Date** _____

Physician's Signature _____ **Date** _____