Sanford Summer Camp
Asthma Mangement 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 incidate your child is having a problem:

_____

Emergency Procedures

List medication, dosage and indication for medication below:

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

List medication kept at camp:

_____

Emergency Contacts

Name _____ Relation to child _____ Phone _____

Name _____ Relation to child _____ Phone_____

Doctor _____ Phone _____

Parent/Gaurdian Signature _____ Date _____

Physician's Signature _____ Date _____