

Asthma/Allergy Plan of Care

Information contained herein is confidential and will be shared only with program staff working directly with the child or with management that provides oversight for the program(s) your child attends. All information is to be used solely for the purpose of better serving and meeting the individual needs of your child.

If a Plan of Care is conducted by phone, a copy will be mailed to the registering parent by the next business day. The registering parent will have 10 business days from the postmark date to make any changes and either mail or fax the altered Plan of Care to the Camp Fire Office. After 10 business days, if no changes have been submitted, the Plan of Care will take effect.

Today's date: _____ Program(s) child will attend: _____

Child's Name: _____ Nickname: _____

Sex: ☐ M ☐ F Age: _____ Birth Date: _____

Allergies

1. Please list all allergies you are aware of.

2. What type of reaction would we see if your child is exposed to an allergen?

3. What level of response is necessary if your child is exposed?

4. Does your child take medication because of this allergy? _____

5. Please list the medications given. Also state if they are given daily or just when exposed.

6. Do you feel that your child would need any accommodations due to this allergy?

Asthma

7. What might trigger an asthma attack?

8. What symptoms might we see if your child begins to experience an Asthma attack?

9. Does your child use an inhaler or other type of Asthma medication?

10. Is this medication given daily or when an Asthma attack occurs?

11. Is your child aware and able to verbalize when medication is needed?

12. What other signs might we see if your child is experiencing an attack?

13. What level of response is needed if there's an asthma attack?

Calm activities

Sit quietly for a few minutes

Other

Immediate phone call to parent

Give inhaler

14. Do you feel that your child might need any accommodations because of the asthma?

(example restricted physical activity)

Parent/Guardian:_____ Relationship to child:_____ Date:_____

Plan of Care conducted at check-in with Camp Nurse? Y/N

Plan of Care conducted by phone? Y/N Date mailed:_____ Date in effect:_____

Camp Director:_____ Date:_____

Camp Nurse:_____ Date:_____

Program Manager:_____ Date:_____

Family Services Manager:_____ Date:_____

At any time, the registering parent or Camp Fire may request a new Plan of Care. Camp Fire's policy requires a review of the Plan of Care 1 year from the date it took effect and a new Plan of Care in 2 years.

Date review completed:_____ Reviewer's name:_____