FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

Date_____ ASTHMA / RAD

Sessions: _____PVW _____1 _____2 _____3 _____4 _____5

Specialty Camp: _____

Child's Name: _____ D.O.B. _____

Concern: **ASTHMA**/**R**eactive **A**irway **D**isease = **RAD** (s/s Asthma)

Known Allergies: _____ NKA

My asthma symptoms are:

Wheeze; Coughing; Shortness of Breath (SOB)

_____

Action steps for when I have these symptoms:

____ Have me sit down and rest. A drink of water may help.

____ Give ___ puffs of MDI (inhaler), _____

prime pump if needed; use spacer; puffs one (1) minute apart;

____ _____

____ Give Nebulizer treatment

****Call 911 if symptoms get worse****

Additional plan for me:

See information above: Notify parent/legal guardian.
Notify Camp Director, or designee.
Complete Medication Administered form.

Additional information: _____

_____

Parent Signature: _____Date:_____

Nurse Name/Signature:_____ Date:_____

MERIDEN YMCA
110 West Main Street Meriden, CT 06451
P 203-235-6386 **F** 203-634-6517
www.meridenymca.org
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Print Name	Signature	Date	Print Name	Signature	Date

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