



TOWNSHIP OF SOUTH BRUNSWICK

Municipal Building • P.O. Box 190 • Monmouth Junction, NJ 08852-0190

DEPARTMENT OF PARKS AND RECREATION

732-329-4000 ext. 7671 email: recreation@sbtnj.net

Phone 732-329-4000 TDD 732-329-2017
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Asthma Action Plan and Inhalers at Camp:

Dear Parent/Guardian,

Thank you for the notification that your child will be bringing an inhaler and/or medication with them to a South Brunswick Parks and Recreation Program. We would like to advise you of our procedures with regard to Asthma attacks. Enclosed you will find an **Asthma Action Plan** sheet. In order for your child to participate in their chosen program(s), this form **MUST** be filled out completely and returned to the Parks and Recreation Department office prior to the program start date.

Parents/Guardians are **required** to:

1. Advise the Parks and Recreation staff member that their child will have an inhaler or medications with them on site. Discuss this with supervisory personnel.
2. **Complete an Asthma Action Plan Sheet. (attached)**
3. Sign the Asthma Action Plan that would permit staff to assist in the administration of the inhaler or medication in the case of an emergency.

When the child arrives on site, with an inhaler or medication, the staff / instructors will:

1. Ensure that they have a completed copy of the paperwork.
2. Ensure the child is carrying a non-expired inhaler or medication.
3. Ask the parents to review the Asthma Action Plan and ensure comprehension of the following:
 - a. What induces the Asthma attack
 - b. What symptoms will the child display in the event of an Asthmatic reaction
 - c. How the staff/ instructors can assist in the administration of the inhaler or medications.

In the event of an Asthma attack:

1. The staff can provide assistance to the child as he/she uses their inhaler **or** the staff can administer the inhaler if the child is unable to do so. Please note that staff are not trained medical professionals and will administer the medications to the best of their ability.
2. Staff will call 911 immediately to have an ambulance come to the site.
3. Staff will call parents/guardians to inform them of the incident and to inform them that the child is being taken to the hospital.
4. Staff will accompany the child to the hospital.

Thank you for the taking the time to read and complete this information. If you have any further questions please feel free to contact the Parks and Recreation Department @732-329-4000 x7671.



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ASTHMA ACTION PLAN

This is due a week prior to participating at camp/program.

Program/Activity _____ Location _____
Child's Name _____ Date of Birth _____
Parent/Guardian _____ Home # _____ Work # _____
Emergency Contact _____ Home # _____ Work # _____
Physician: _____ Work # _____

My child's Asthma is induced by:

- | | | | | |
|---|--|---|---|-----------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Illness (colds, etc.) | <input type="checkbox"/> Laughing or crying | <input type="checkbox"/> Allergies | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Pollen | <input type="checkbox"/> Mold | <input type="checkbox"/> Humidity/Heat | <input type="checkbox"/> Weather changes | <input type="checkbox"/> Cold air |
| <input type="checkbox"/> Airborne chemicals, smoke, odors or dust | <input type="checkbox"/> Dust mites | <input type="checkbox"/> Animals with fur | <input type="checkbox"/> Child's asthma triggers are unknown. | |
| <input type="checkbox"/> Other triggers _____ | | | | |

MY CHILD'S ASTHMA SYMPTOMS ARE:

- | | | |
|--|---|--|
| <input type="checkbox"/> Wheezing/whistling sound when breathing | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Fainting or loss of consciousness |
| <input type="checkbox"/> Tightness / heaviness in chest | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Swelling (eyes, lips, face, tongue) |
| <input type="checkbox"/> Change of voice/ hoarseness | <input type="checkbox"/> Coughing | <input type="checkbox"/> Pale skin |
| <input type="checkbox"/> Cold clammy, sweaty skin | <input type="checkbox"/> Flushed face or body | <input type="checkbox"/> Dizziness, confusion |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Choking | <input type="checkbox"/> Stomach cramps/diarrhea |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tiredness | <input type="checkbox"/> Restlessness / irritability |
| <input type="checkbox"/> Other (list) _____ | | |

MY CHILD'S EMERGENCY TREATMENT IS:

- _____
- | | |
|---|--|
| <input type="checkbox"/> Inhaler Expiration Date _____ | <input type="checkbox"/> Steroid medication or other medication _____ |
| <input type="checkbox"/> *Nebulizer with medication (see below) _____ | <input type="checkbox"/> Anti-histamine (with precise measuring instrument- specific brand and dosage) _____ |

NOTE: Inhaler/and medication must be provided and not yet expired. Nebulizer treatments may not be kept on program premises.

MEDICATION STORAGE:

I prefer my child's medication be stored:

- | | |
|---|--|
| <input type="checkbox"/> Inside the building in the camp office | <input type="checkbox"/> In a first aid kit with a counselor in my child's group |
|---|--|

STAFF PLAN

1. CALL 911 AND TELL THE DISPATCHER THAT A CHILD IS HAVING A LIFE THREATENING ASTHMA ATTACK
2. CALL PARENTS OR GUARDIANS

3. OTHER INSTRUCTIONS

PARENT/GUARDIAN SIGNATURE _____ DATE _____

STAFF/INSTRUCTOR SIGNATURE _____ DATE _____

Asthma Action Plan



Name _____ DOB ____/____/____

Severity Classification Intermittent Mild Persistent Moderate Persistent Severe Persistent

Asthma Triggers (list) _____

Peak Flow Meter Personal Best _____

Green Zone: Doing Well

Symptoms: Breathing is good - No cough or wheeze - Can work and play - Sleeps well at night

Peak Flow Meter _____ (more than 80% of personal best)

Control Medicine(s)	Medicine	How much to take	When and how often to take it
	_____	_____	_____
	_____	_____	_____

Physical Activity Use albuterol/levalbuterol ____ puffs, 15 minutes before activity
 with all activity when you feel you need it

Yellow Zone: Caution

Symptoms: Some problems breathing - Cough, wheeze, or chest tight - Problems working or playing - Wake at night

Peak Flow Meter _____ to _____ (between 50% and 79% of personal best)

Quick-relief Medicine(s) Albuterol/levalbuterol ____ puffs, every 4 hours as needed

Control Medicine(s) Continue Green Zone medicines
 Add _____ Change to _____

You should feel better within 20-60 minutes of the quick-relief treatment. If you are getting worse or are in the Yellow Zone for more than 24 hours, THEN follow the instructions in the RED ZONE and call the doctor right away!

Red Zone: Get Help Now!

Symptoms: Lots of problems breathing - Cannot work or play - Getting worse instead of better - Medicine is not helping

Peak Flow Meter _____ (less than 50% of personal best)

Take Quick-relief Medicine NOW! Albuterol/levalbuterol ____ puffs, _____ (how frequently)

Call 911 immediately if the following danger signs are present

- Trouble walking/talking due to shortness of breath
- Lips or fingernails are blue
- Still in the red zone after 15 minutes