

ASTHMA HISTORY & TREATMENT FORM

SPIRIT in the PINES Camp - Counselor / CIT / Staff

Participant's Name _____ Date _____

Parent's Name _____ Phone (H) _____

Address _____ Phone (W) _____

Physician treating participant's asthma _____ Phone _____

1. How long has the participant had asthma? _____

2. Please rate the severity of his/her asthma. (circle one)

(Not severe) 1 2 3 4 5 6 7 8 9 10 (Severe)

3. What triggers the participant's asthma attacks? (Please check any that apply and describe as fully as possible.)

_____ Illness

_____ Emotions

_____ Medications

_____ Weather

_____ Exercise

_____ Smoke

_____ Foods

_____ Fatigue

_____ Chemical odors

_____ Allergies (Please list) _____

_____ Other (Please list) _____

4. What does the participant do at home to relieve wheezing during an asthma attack? (Please check any that apply.)

_____ Rest/Relaxation

_____ Drinks liquids

_____ Breathing exercises (Please describe)

_____ Takes medication:

_____ Inhaler _____

(name medication)

_____ Nebulizer _____

_____ Oral medication _____

_____ Other (Please describe) _____

5. In which sports can the participant fully participate?

6. What medications does the participant take and how often?
Every day _____
Just for wheezing/attacks _____
Before exercise _____
Certain times of the year or when ill _____
7. What, if any, side effects does the participant have from his/her medication?
8. Does the participant understand asthma and what he or she should do to manage it?
9. Approximately how often does the participant have an acute episode?
10. How do you want SPIRIT in the PINES staff to treat an episode of asthma if it should occur?
11. If the participant does not respond to medication what action should the SPIRIT in the PINES staff take?

COMMENTS:

Signature of Parent/Guardian or participant if age 18 & over _____