

ASTHMA FORM – CINCINNATI MUSEUM CENTER CAMPS

May 27 – August 8, 2025

We want your child to receive appropriate support for their asthma while attending CMC camps. It is our expectation that your child is capable of self-managing their asthma: knowing when to amend their activity level, use their rescue inhaler, and when to seek help. All other asthma medications will be stored and administered in accordance with CMC policies. We are happy to work with you to try to accommodate your camper's need as much as possible.

Camper Name: _____ Age: _____

If applicable Prescriber's Name/Title: _____

If applicable Prescriber's place of employment: _____

If applicable Address: _____

If applicable Telephone: _____

If applicable Prescriber's Signature: _____ Date: _____

Diagnosis / Reason for Medication:

Asthma Triggers to Avoid for Camper:

___ Asthma ___ Other: _____
___ Smoke / fumes ___ Animal
___ Mold Spores ___ Dust Mite
___ Other: _____

YES / NO: Camper is required to have quick relief asthma medication to provide rapid relief of asthma symptoms if needed:
cough, chest tightness, wheezing, trouble breathing, shortness of breath

YES / NO: Camper is required to use quick relief asthma medication BEFORE physical activity to prevent activity-induced bronchospasm from asthma

YES / NO: Camper is required to take daily asthma control medication at camp as directed

Medication Information	
Name of Medication	Albuterol: _____ Other: _____
Form of Medication	___ Inhaler ___ Nebulizer ___ Dry Powder Inhaler ___ Liquid ___ Pill / Capsule
Dosage of Medication	Number of puffs: _____ Other: _____
Other instructions	YES / NO: Inhaler MUST be used with a spacer (valved holding chamber) for administration YES / NO: Please maintain a written record (Log) of all doses
When to administer dose	YES / NO: 5-15 minutes before physical activity to prevent activity-induced bronchospasm YES / NO: As needed for FAST RELIEF of chest tightness, shortness of breath, wheezing or prolonged cough or other asthma symptoms. A total of 3 doses can be given within an 8 hour interval YES / NO: Daily at _____ AM / PM for daily asthma control (long term prevention)
Repeat Dose	_____: Do NOT repeat the dose _____: Repeat dose one time if symptoms not gone 10 minutes after first dose AND repeat does every 3-4 hours IF symptoms RECUR during the day
When to call Camper's Parent/Legal Guardian	If after 2 consecutive doses (2-4 puffs per dose) are given and there is no improvement in symptoms, please seek further medical attention and call parent/legal guardian

Asthma Emergency The steps that should be taken: <ul style="list-style-type: none"> • Activate the emergency medical system in your area. Call 911. • Call Parent/Guardian and/or Healthcare Provider 		The following are possible signs of an asthma emergency: <ul style="list-style-type: none"> • Difficulty breathing, walking, or talking • Blue or gray discoloration of the lips or fingernails • Failure of medication to reduce worsening symptoms. 	
Supervision of Medication		____: Camper is permitted to carry medication and self-administer with no supervision ____: Camper MAY self-administer medication BUT supervision is required for all doses ____: Camper require trained assistance to administer all doses	
Expected Normal Side Effects	____None	____Fast heartbeat, tremor, hyper-activity	Other:_____
Storage Requirements	____None	____Refrigerate	Other:_____

Can your camper self-carry an Inhaler? ____ Yes ____ No

Staff will make sure that the Inhaler is with the camper at all times during the day.

Inhaler must be brought on the first day and will be returned at the end of the week. Inhaler will be stored in a safe location overnight throughout the week and cannot be kept at camp over the weekend. Please indicate in the special instructions if you want your camper to bring their Inhaler home daily.

Please list any special instructions:

Parent/Legal Guardian Authorization and Release

I, _____, hereby authorize the CMC camp medical coordinators and/or camp staff members to administer the asthma medication listed above or to supervise the camper in self-administration of such medication. I certify that I have legal authority to consent to medical treatment for the child named above, including the administration of asthma medication at the facility.

I, on behalf of myself, my executors, administrators, heirs, next of kin, and successors, hereby covenant to hold harmless and indemnify the CMC and all of its officers, departments, agencies, agents, and employees from any and all claims, losses, damages, injuries, fines, penalties, and costs (including court costs and attorney's fees), charges, liabilities, or exposures, however caused, resulting from, arising out of, or in any way connected to assisting the above named camper with the use of asthma medication. I have read and understand this Authorization and Release and by my signature I agree to its terms.

Parent/Legal Guardian Signature: _____ Date: _____

Please notify us immediately of any changes on this form. Museum Camp Manager (513) 728-0082
camps@cincymuseum.org