Quick Reference Card
for Camp Counselors and Staff

Camper Name _____ Nickname _____
Last First

Healthcare Staff _____ / _____
Name Role Name Role

Counselor Name _____ Cabin _____
First Nickname

Exercise Induced Asthma ☐ Yes ☐ No Pretreats for EIA ☐ Yes ☐ No

Food Allergies ☐ Yes ☐ No Type(s) _____

Animal/Insect Reactions ☐ Yes ☐ No Type(s)_____

Emotional/Behavior Issues ☐ Yes ☐ No Description _____

_____

On Regular Med Schedule ☐ Yes ☐ No Exceptions _____

Relative/Friend at Camp ☐ Yes ☐ No Who/Cabin _____

Birthday During Camp ☐ Yes ☐ No Date/Age _____

Notes _____

_____

_____

© 2001, Consortium of Children's Asthma Camps