







Asthma Visit Sheet

Asthma Visit # _____

Name: _____ Cabin: _____ Date: _____

For Campers

1. How tight is your chest?
2. How hard is it to breathe?
3. How bad is your cough?

<i>When you come in</i>			<i>Before you leave</i>		
Not at all	Sort of	The worst	Not at all	Sort of	The worst
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
					

For Nurses Only

Time			
Comment(s) made by camper			
Peak flow			
Heart rate			
Retracing			
Respiratory rate			
Breath sounds/wheezing			
Air exchange			
Anxiety level			
Treatment action			
Evaluation/outcome			
Nurse's Signature			