

Asthma Health Care Plan

Name of child: _____ Date of birth: _____

Parent(s) or guardian(s) name: _____

Emergency phone numbers: Mother: _____ Father: _____

(See emergency contact information for alternate contacts if parents are unavailable)

Primary health provider's name: _____ Emergency Phone: _____

Asthma specialist's name (if any): _____ Emergency Phone: _____

Known Triggers for this child's asthma (Check all that apply):

- | | | | |
|-----------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Colds | <input type="checkbox"/> Tree pollens | <input type="checkbox"/> Flowers | <input type="checkbox"/> Animals |
| <input type="checkbox"/> Mold | <input type="checkbox"/> House dust | <input type="checkbox"/> Excitement | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors | <input type="checkbox"/> Weather changes | <input type="checkbox"/> Room deodorizers |
| | <input type="checkbox"/> Grass | | |

Foods (specify): _____

Other (specify): _____

Activities for which this child has needed special attention in the past (Check all that apply):

Outdoor Activities

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Running Hard | <input type="checkbox"/> Outdoors on cold or windy days | <input type="checkbox"/> Field trip to see animals |
| <input type="checkbox"/> Gardening | <input type="checkbox"/> Playing in fresh cut grass | <input type="checkbox"/> Jumping in leaves |

Indoor Activities

- | | | |
|--|---|---|
| <input type="checkbox"/> Sitting in carpet | <input type="checkbox"/> Painting or renovation in facility | <input type="checkbox"/> Art projects with chalk, glues or fumes |
| <input type="checkbox"/> Pet care | <input type="checkbox"/> Kerosene/wood stove heated rooms | <input type="checkbox"/> Recent pesticide application in facility |

Other Activities (specify): _____

Can this child use a **flowmeter** to monitor need for medication in child care: Yes No

Personal best reading _____ Reading to give extra dose of medication _____ Reading to get medical help _____

How often has this child needed urgent care from a doctor for an attack of asthma?

In the past 12 months: _____ In the past 3 months: _____

Typical signs and symptoms of this child's asthma episodes (Check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Flaring nostrils, mouth open panting | <input type="checkbox"/> Sucking in chest/neck |
| <input type="checkbox"/> Breathing faster | <input type="checkbox"/> Face is red, pale or swollen | <input type="checkbox"/> Persistent coughing |
| <input type="checkbox"/> Restlessness/Agitation | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Gray or blue lips or fingernails |
| <input type="checkbox"/> Complaints of chest pain or tightness | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Difficulty playing, eating, drinking or talking |
| | <input type="checkbox"/> Grunting | |

Reminders:

1. Notify parents immediately if emergency medication is required.
2. Get emergency medical help if:
 - > The child does not improve 15 minutes after treatment and family cannot be reached
 - > After receiving treatment for wheezing the child:
 - Is working hard to breath or is grunting
 - Is breathing fast at rest (>50 breaths/minute)
 - Has trouble walking or talking
 - Has nostrils open wider than usual
 - Is extremely agitated or sleepy
 - Sucking in of skin on chest or neck when breathing
 - Won't play
 - Has gray or blue lips or fingernails
 - Cries more softly or briefly
 - Is hunched over to breathe
3. Child's doctor and child care facility should keep a copy of this form in child's record.

Asthma Medications

for routine and emergency treatment of asthma for:

Name of Child: _____ **Date of Birth:** _____

Name of Medication:			
When to Use: (e.g. symptoms, time of day, frequency etc.)	<input type="checkbox"/> Routine <input type="checkbox"/> Emergency	<input type="checkbox"/> Routine <input type="checkbox"/> Emergency	<input type="checkbox"/> Routine <input type="checkbox"/> Emergency
How to Use: (e.g. by mouth, by inhaler, with or without spacing device, in nebulizer, with or without dilution, diluting fluid etc.)			
Amount or Dose of Medication:			
How soon should treatment start to work?			
Expected benefits to child			
Possible side affects (if any):			
When instructions were last updated by child's doctor:	Date: _____ Name of Doctor (print): _____ Doctor's signature: _____		
Parent's permission to follow this medication plan:	Date: _____ Parent's signature: _____		

Copy this page if more columns are needed for medication or equipment instruction.

Resources :

Child Care and Children with Special Needs Workbook.
Wilmington, DE: Video Active Productions, 2001 302-477-9440

Form provided by Child Care Aware® of North Dakota Health Consultants.

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