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 heath provider's name: _____ Emergency Phone: _____

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

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

- ☐ Colds
- ☐ Mold
- ☐ Exercise
- ☐ Tree pollens
- ☐ House dust
- ☐ Strong odors
- ☐ Grass
- ☐ Flowers
- ☐ Excitement
- ☐ Weather changes
- ☐ Animals
- ☐ Smoke
- ☐ Room deodorizers
- ☐ Foods (specify): _____
- ☐ Other (specify): _____

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

Outdoor Activities

- ☐ Running Hard
- ☐ Gardening
- ☐ Outdoors on cold or windy days
- ☐ Playing in fresh cut grass
- ☐ Field trip to see animals
- ☐ Jumping in leaves

Indoor Activities

- ☐ Sitting in carpet
- ☐ Pet care
- ☐ Painting or renovation in facility
- ☐ Kerosene/wood stove heated rooms
- ☐ Art projects with chalk, glues or fumes
- ☐ 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):

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

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.)	☐ Routine ☐ Emergency	☐ Routine ☐ Emergency	☐ Routine ☐ 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.

Revised 2/22