

**Asthma Health Care Plan**

## Name of child: Date of birth: Parent(s) or guardian(s) name:

**Emergency phone numbers:** Mother:

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

### Father:

**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):

 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

## Indoor Activities

* Sitting in carpet
* Pet care
* Outdoors on cold or windy days
* Playing in fresh cut grass
* Painting or renovation in facility
* Kerosene/wood stove heated rooms
* Field trip to see animals
* Jumping in leaves
* 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

# Reminders:

* 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
	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
	1. Child’s doctor and child care facility should keep a copy of this form in child’s record.

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**Asthma Medications** for routine and emergency treatment of asthma for:

# Name of Child: Date of Birth:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Medication: |  |  |  |
| When to Use:(ex. symptoms, time of day, frequency etc.) |  Routine  Emergency |  Routine  Emergency |  Routine  Emergency |
| How to Use:(ex. 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 effects (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.

Form provided by Child Care Aware® of North Dakota Health & Safety Specialists Revised 1/24

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