# Asthma Care Plan

Child's Name_______________________________________ Date of Birth _____/_____/_____
Parent/Guardian Name ________________________________
Emergency Phone Numbers: Mother (     ) ____-_______ Father Mother (     ) ____-_______
Primary Health Provider Name ______________________ Emergency Phone (     ) ____-_______
Asthma Specialist's Name _________________________ Emergency Phone (     ) ____-_______

**Known Triggers for Child's Asthma:** (Check all that apply):

[ ] Colds [ ] Mold [ ] Exercise [ ] Tree Pollens [ ] House [ ] Dust
[ ] Strong Odor [ ] Grass [ ] Flowers [ ] Excitement [ ] Animals [ ] Smoke

[ ] Food, specify ____________________________________
[ ] Other, specify ____________________________________

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

Outdoors
[ ] Field Trips to see animals
[ ] Running hard
[ ] Gardening
[ ] Jumping in leaves
[ ] Outdoors on cold or windy days
[ ] Playing in fresh cut grass
[ ] Other, specify_____________________________

Indoors
[ ] Art projects w/ chalk, glues, fumes
[ ] Sitting on carpet
[ ] Pets care
[ ] Recent pesticides application in facility
[ ] Painting or renovation in facility

Can this child use a flowmeter to monitor need for medication in child care? [ ] Yes [ ] Yes
If yes, personal best reading: _______
Reading to give extra dose of medicine: _______
Reading for medical help: _______

How often has this child needed urgent care from a doctor for an attack of asthma in the:
Past 12 months?_____________ Past 2 months?_____________

Typical Signs and Symptoms of the child's asthma episodes: (Check all that apply)

[ ] Fatigue
[ ] Wheezing
[ ] Persistent Cough
[ ] Gray or blue lips/nails
[ ] Face red, pale, or swollen
[ ] Sucking in chest neck
[ ] Grunting
[ ] Restlessness
[ ] Dark circles under eyes
[ ] Flaring nostrils, mouth open (panting)
[ ] Difficulty playing, eating, drinking, talking
[ ] Breathing faster
[ ] Agitation

**Reminders**

1. Notify parents **immediately** if emergency medication is required.
2 Get emergency medical help if:
   - Child does not improve 15 minutes after treatment and family cannot be reached
   - After receiving a treatment for wheezing, the child
     - Is working hard to breathe or grunting
     - Is breathing fast at rest
     - Has trouble walking or talking more softly and briefly
   - Has nostrils open wider than usual
   - Has suckling in skin (chest or neck) while breathing
   - Extremely agitated or sleepy
   - Won't Play
   - Grey or blue lips/fingernails
   - Cries more softly and briefly
   - Hunched over to breathe
   - Extremely agitated or sleepy

3. Child's doctor and child care facility should keep a current copy of this form in child's record.

# Asthma Care Plan

Medications for routing and emergency treatment of asthma for:

Child's Name ________________________________________ Date of Birth _____/_____/_____

Name of Medication: ______________________________________________

| | |
|---|---|
| When to use (e.g., symptoms, time of day, frequency, etc. | |
| How to use( e.g., by mouth, by inhaler, with or without special device, in nebulizer, with or without dilution, diluting fluid) | |
| Amount (dose) of medication | |
| How soon treatment should start to work | |
| Expected benefit for child | |
| Possible benefit of child | |
| Possible side effects, if any | |
| Date instructions were last updated by child's doctor | _____/_____/_____ |

Doctor's Name: __________________________

________________________________________
Doctor's Signature Date _____/_____/_____

I authorize Kids Central, Inc. to follow the medication plan specified above:

________________________________________
Parent's Signature Date _____/_____/______