Special Care Plan for a Child with Asthma

Child's Name_____Date of Birth:_____

Parent's Names_____

Emergency Phone numbers mother_____ father_____
(See emergency contacts for alternates if parents are unavailable)

Primary Health Provider's Name:_____ Phone:_____

Asthma Specialist's Name:_____ Phone:_____

Known triggers for this child's asthma (circle all that apply)

Colds	Tree pollens	Grass	Flowers
Mold	Exercise	House dust	Weather changes
Animals	Strong Odors	Excitement	Smoke

Room Deodorizers
Foods (specify)_____
Other (specify)_____

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

Outdoors	Indoors
Field trips to see animals/farms	Kerosene/wood stove heated rooms
Running hard	Art projects with chalk, glues, fumes
Gardening	Sitting on carpets
Jumping in leaves	Pet Care
Outdoors on cold or windy days	Painting or renovations
Fresh cut grass	Other (specify)_____

Can this child use a flowmeter to monitor need for medication in child care? ☐Yes ☐ No
Personal Best reading_____ Reading to give an 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?_____

Medications (routine and emergency): See chart on page 2 of this form.

_____ _____
Signature of child's parent Date Signed

_____ _____
Signature of child's health provider Date Signed

_____ _____ _____
Name of health professional to call for questions or staff training. Phone # Date to Review/Update Plan

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 can not be reached
*after receiving a treatment for wheezing, the child:

Is working hard to breathe or grunting	Has sucking in a skin (chest/neck) with breathing
Is breathing fast at rest (>50/min)	Has grey or blue lips or fingernails
Won't play	Cries more softly and briefly
Has trouble walking or talking	Is hunched over to breathe
Has nostrils open wider than usual	Is extremely agitated or sleepy

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

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Medications for Routine 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.)	Routine or Emergency	Routine or Emergency	Routine or Emergency	Routine or 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 (dose) of Medication				
How soon treatment should start to work				
Expected benefit for the child				
Possible side effects, if any				
Date 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_____			