



Plan of Care for **Asthma** (©AYS, Inc.)

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

AYS Program: _____

Physician child sees for Asthma:

Name (please print) Phone Number

Medications your child uses for his/her asthma:

Name of Medication(s)	Dosage	Time(s) of day given

Would medications(s) need to be given during normal program hours?.....YES/NO
Would medication(s) need to be given during non-school day programs?YES/NO
If **yes** to either question, an AYS permission slip, completed by your physician is required. Have you returned this permission slip to the AYS director?YES/NO

Allergies: List any allergies i.e. foods, medications, the environment, etc. _____

Identify the things that start an asthma episode (check any that apply to your child)

- Animals Bee/insect sting Chalk dust Change in temperature
 Dust mites Exercise Latex Molds
 Pollens Respiratory infections Smoke Strong odors
 Food _____
 Other _____

Control of the Child Care Environment

List any environmental control measures, premedications &/or dietary restrictions that your child needs to avoid an asthma episode: _____

Outside activity & field trips List the medications that must accompany your child on these activities.

Name	Dosage	When to use

YOUR child's symptoms of an asthma attack: (Check any that apply to your child)

- Difficulty breathing Coughing Wheezing Grunting
- Chest feels tight Can't catch his/her breath Nostril flaring
- Hunches over to breathe easier Speaks in very short, choppy sentences
- Skin, lips &/or fingernails look gray, blue or purple Shortness of breath
- Retractions of the areas over the stomach &/or ribs
- Other _____

The usual procedure at AYS for a child having an asthma attack:

1. Remove child from the environment of his/her trigger agent(s).
2. Let the child find a position comfortable to him/her.
3. Attempt to calm & reassure the student.
4. Assess for the severity of the attack.
5. If parents have provided a peak flow meter, take a reading & compare to child's desired peak flow reading.
6. Give **emergency medications** listed below if child is experiencing the following:
SYMPTOMS: _____

A PEAK FLOW READING BELOW: _____

7. Check for decreased symptoms &/or increased peak flow reading.
8. Contact parent/guardian.
9. Seek **Emergency Medical Services** if child is not improving.

EMERGENCY asthma medication(s)

Name	Dosage	When to use

**Does your child have your permission to carry their own emergency asthma inhaler:.....YES/NO

1. Child has demonstrated correct use of inhaler.
2. Child agrees to never share or misuse inhaler.
3. Child agrees that after 2 puffs, if there is not improvement, he/she will tell the director so that parents can be notified.

Review of the above information & signatures for this school year in AYS:

Parent/Guardian Signature

AYS Program Director's Signature

Date

Date

Review of the above information & signatures for the next school year in AYS:

Parent/Guardian Signature

AYS Program Director's Signature

Date

Date