Plan of Care for Asthma

Child's Name: ______________________________ **Date of Birth:** __________________ **Age:** ________

AYS Program: ________________________ **School Year:** ________________________

Physician child sees for Asthma:

____________________________________ ________________________

Name (please print) (Physician's Phone Number)

Medications your child uses for prevention of his/her allergy:

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

(* Please list medications for emergency treatment of an allergic reaction on next page.)

Would medication(s) need to be given during normal program hours? ☐ YES ☐ NO

Would medication(s) need to be given during non-school days? ☐ YES ☐ NO

If **yes** to either question, an AYS Medication Consent form, completed by your child's doctor is required.

Have you returned this form 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 and/or dietary restrictions that your child needs in order to avoid an asthma episode. ____

____

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

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<u>YOUR</u> 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 and/or fingernails look gray, blue or purple ☐ Shortness of breath
☐ Retractions of the areas over the stomach and/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 and reassure the child.
4. Assess for the severity of the attack.
5. If parents have provided a peak flow meter, take a reading and compare to child's desired peak flow reading.
6. Give **emergency medications** listed below <u>if child is experiencing the following</u>:
   SYMPTOMS: ____
   A PEAK FLOW READING BELOW: ____________________________
7. Check for decreased symptoms and/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 two puffs, if there is not improvement, he/she will tell the director so that parents can be notified.

Review of above information and signatures for the ______________ school year in AYS *(1st year)*:

______________________________ ______________________________
Parent/Guardian Signature AYS Program Director's Signature

______________________________ ______________________________
Date Date

Review of above information and signatures for the ______________ school year in AYS *(2nd year)*:

______________________________ ______________________________
Parent/Guardian Signature AYS Program Director's Signature

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