Plan of Care for Asthma

Child's Name:_____Date of Birth:_____Age:____
Program Site:_____ School Year_____

Medications your child uses for his/her asthma:
*(*Please list medications for Emergency treatment of an asthma attack on next page.)*

Name	Dosage	Time of day given

Would any of the above medication(s) need to be given during program hours? ___Yes* ___No
If yes, a medication form must be filled out by the physician and returned **before your child can receive any medication*

Allergies: List any allergies (food, med, environmental, etc.)_____

Identify the things that could start an asthmatic episode (check any that apply child):

___Animals ___Bee/Insect Sting ___Change in temp ___Dust mites
___Exercise ___Latex ___Molds ___Pollens
___Smoke ___Strong odors ___Respiratory Infections
___Foods*_____
___Other_____

**Must have a physician signed Medical Statement for Children with Special Dietary Needs on file for the program's nutrition program.*

Control of the Program environment:
List any environmental control measures, and/or dietary restrictions that your child needs to avoid an asthma episode (ozone warning, heat index, and food):

_____
_____

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)

___Difficulty breathing ___Coughing ___Wheezing ___Grunting
___Chest feels tight ___ Nostril flaring ___Can't catch his/her breathe
___Hunches over to breathe easier ___Speaks in very short, choppy sentences
___Shortness of breath ___Skin, lips &/or fingernails look gray, blue or purple
___Other_____

The usual procedures at LEARN for a child having a suspected 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 child.
4. Assess for the severity of the attack.
5. If parents/guardians provide a peak flow meter, take a reading & compare to child's desired peak flow reading.
6. Give **emergency medications** listed below <u>if child is experiencing the following:</u>
   SYMPTOMS:_____
   _____
7. Check for decreased symptoms &/or increased peak flow reading.
8. Parent/guardian will be notified of any asthmatic symptoms, whether mild or severe.
9. Seek **Emergency Medical Services** if child is not improving.

EMERGENCY Asthma Medications(s)

Name	Dosage	When to use

Did you provide LEARN with <u>emergency medication</u>? ____Yes* ____No

If you provide the program with **emergency medication such as an inhaler, a medication form **must** be filled out **<u>before</u>** your child can receive any medication.*

_____ _____
Parent/Guardian Signature & Date *Site Director Signature & Date*

Review of above information and signature for _____school year in LEARN.

_____ _____
Parent/Guardian Signature & Date *Site Director Signature & Date*

Review of above information and signature for _____school year in LEARN.

_____ _____
Parent/Guardian Signature & Date *Site Director Signature & Date*