

# Asthma Care Plan

Childs Name: \_\_\_\_\_  
Facility Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Div: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

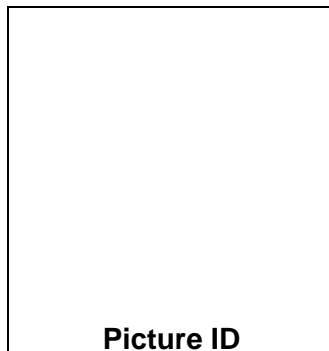
Parent/Guardian: \_\_\_\_\_

Phone (home/cell): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Office Phone: \_\_\_\_\_



• **GIVE** \_\_\_\_\_  
(name of medication)

• **Follow Instructions:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

• **If unsure, child is worse, or not getting better CALL 911**

• **CALL PARENTS**

*It is the parent's responsibility to notify the facility of any change in the child's condition.*

Sign below if you agree with above Information & Plan:

\_\_\_\_\_  
Health Care Provider (ie. Dr/Specialist/NP)      Date

\_\_\_\_\_  
Parent/Guardian      Date

\_\_\_\_\_  
Childcare Supervisor/School Personnel      Date

## CHILD'S ASTHMA TRIGGERS ARE:

- |  |   |                                      |   |                                |  |                                 |
|--|---|--------------------------------------|---|--------------------------------|--|---------------------------------|
| <input type="checkbox"/> change in temperature | <input type="checkbox"/> colds, infection | <input type="checkbox"/> dust, mites | <input type="checkbox"/> emotion (e.g. upset) | <input type="checkbox"/> mould | <input type="checkbox"/> physical activity | <input type="checkbox"/> pollen |
| <input type="checkbox"/> animals               | (list): _____                             |                                      |   |                                |  |                                 |
| <input type="checkbox"/> foods                 | (list): _____                             |                                      |   |                                |  |                                 |
| <input type="checkbox"/> strong smells         | (list): _____                             |                                      |   |                                |  |                                 |
| <input type="checkbox"/> Other:                | _____                                     |                                      |   |                                |  |                                 |

## CHILD'S ASTHMA SYMPTOMS ARE USUALLY:

- |   |  |
|---|--|
| <input type="checkbox"/> appears anxious        | <input type="checkbox"/> short of breath         |
| <input type="checkbox"/> coughing               | <input type="checkbox"/> wheezing                |
| <input type="checkbox"/> difficulty talking     | <input type="checkbox"/> in-drawing/tracheal tug |
| <input type="checkbox"/> fast/shallow breathing | <input type="checkbox"/> other (list below):     |
| <input type="checkbox"/> pale                   | <input type="checkbox"/>                         |
| <input type="checkbox"/> hunched over           | <input type="checkbox"/>                         |

## CHILD'S EMERGENCY TREATMENT:

- Medication is stored: \_\_\_\_\_
- Medication expiry date: \_\_\_\_\_
- Names of staff oriented to plan: \_\_\_\_\_
- Emergency plan review date (to do yearly): \_\_\_\_\_
- Field Trip Plans: \_\_\_\_\_