Asthma Care Plan

Childs Name: ______________________ **Grade:** ________ **Div:** ______

Facility Name: ______________________ **Facility Address:** ______________________

Child's Full Name:

Date of Birth:

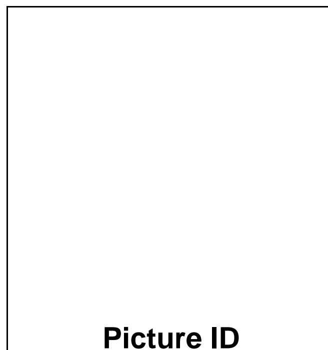
Parent/Guardian:

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

Emergency Contact:

Phone (home): Phone (work):

Health Care Provider: Office Phone:



CHILD'S ASTHMA TRIGGERS ARE:

☐ change in temperature ☐ colds, infection ☐ dust, mites ☐ emotion (e.g. upset) ☐ mould ☐ physical activity ☐pollen

☐ animals (list): ______________________

☐ foods (list): ______________________

☐ strong smells (list): ______________________

☐ Other: ______________________

CHILD'S ASTHMA SYMPTOMS ARE USUALLY:

☐ appears anxious

☐ coughing

☐ difficulty talking

☐ fast/shallow breathing

☐ pale

☐ hunched over

☐ short of breath

☐ wheezing

☐ in-drawing/tracheal tug

☐ other (list below):

☐

☐

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:

- **GIVE** ______________________
  (name of medication)
- **Follow Instructions:** ______________________

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- **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 ________

Asthma Care Plan is provided as a resource from Vancouver Coastal Health – April 2013

Vancouver Coastal Health
Promoting wellness. Ensuring care.