

Asthma Care Plan

Childs Name: _____

Grade: _____ Div: _____

Facility Name: _____ Facility Address: _____

Child's Full Name: _____

Date of Birth: _____

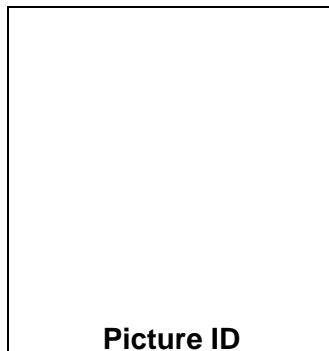
Parent/Guardian: _____

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

Emergency Contact: _____

Phone (home): _____ Phone (work): _____

Health Care Provider: _____ Office Phone: _____



Picture ID

• **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:

- 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: