INDIVIDUAL HEALTH PLAN / EMERGENCY CARE PLAN FOR CHILD WITH ASTHMA/REACTIVE AIRWAY DISEASE (RAD)

Child's Name: ____ Birth Date: __________

Program Name/Site: ____ Grade: ____________

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1. Where does your child receive his/her Asthma/RAD care?

   Health Care Provider/Clinic ____________________________ Phone Number: _____________

2. How many times has your child been treated in the emergency department or hospitalized for Asthma/RAD in the past year? ________

3. What triggers your child's Asthma/RAD attacks?

   ☐exercise ☐weather changes ☐emotional stress
   ☐upper respiratory infections ☐smoke
   ☐allergies (please list): ____

4. What are your child's usual signs and symptoms of an Asthma/RAD attack? (Please check all that apply)

   ☐constant/frequent cough ☐wheezing
   ☐difficulty breathing/talking ☐chest tightness
   ☐other: ____

5. Does your child recognize these signs and symptoms? ☐ YES ☐ NO

6. What does your child do at home to relieve signs/symptoms of an asthma/RAD attack? (Please check all that apply) ☐breathing exercises ☐drinks liquid
   ☐rests ☐medication

7. Please list medication taken daily at home for asthma/RAD:

   Oral: ____

   Inhaled: ____

8. <u>Emergency Contacts</u> (*list in order of who to call first*)

Name: ____________________ Relationship:____________ Daytime Phone:____________Cell:___________

Name: ____________________ Relationship:____________ Daytime Phone:____________Cell:___________

<u>CER ASTHMA ACTION/EMERGENCY PLAN</u>

1. Calm and reassure child.
2. Give inhaler/nebulizer if available as authorized by parent/guardian and prescribed by health care provider.
3. Have child in sitting position, encourage slow breathing (in through nose and out through pursed lips).
4. Offer sips of water.
5. Call parent/guardian if child's breathing has not improved or if medication does not relieve symptoms in 15 minutes.

Call 911 and parents if symptoms are not improving with ANY of the following signs or symptoms:

• Breathing is hard and fast • Student cannot talk or walk • Ribs show • Nose opens wide to breathe

<u>OVER</u>

Child's Name: ___________________________

CER MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION

☐ **No inhaler/nebulizer at program.**

- Call parent if attack occurs.
- Follow CER Emergency Asthma/RAD Plan.

☐ **Inhaler/nebulizer to be administered during program as ordered by physician/licensed prescriber.**

- CONSENT FOR ADMINISTRATION OF MEDICATION form must be filled out before program personnel can accept inhaler/nebulizer.
- Child may use inhaler/nebulizer in the presence of program personnel. Program personnel to administer for child if needed.
- Follow CER emergency plan.

1. I understand that this plan may be shared with all program staff working directly with my child.
2. I will contact the program if a change in the current plan is needed.

Parent/Guardian Signature: ____ Date: ____________________