Child Health Plan and Provider Orders -
Respiratory Disorder

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Center:	☐ ECEAP	☐ Head Start	☐ Early Head Start
Child's Name:	**Date of Birth:**		Gender: ☐ M ☐ F
Parent/Guardian:	**Phone:** (Home)		(Cell)
Does this child have any of the following? (check one)	☐ IEP	☐ IFSP	☐ 504 Plan

This child has been diagnosed with: ☐ Asthma ☐ RAD ☐ RSV (EHS only)

If asthma, please check level of severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Seasonal/When ill

When was your child's last episode?

What steps did you take to resolve it?

What will your child say or do during an episode?

What symptoms occur when your child has an episode? (check all that apply)

☐ Coughing ☐ Wheezing ☐ Shortness of Breath ☐ Tight Chest ☐ Tired ☐ Other:

Call 911, then Parent/Guardian for the following signs and symptoms:

- Symptoms above continue for 10 minutes after giving medication
- Difficulty talking or walking
- Continuous coughing
- Chest, neck, or ribs sucking in
- Lips or fingernails turning pale or blue
- Bending over to breath
- Gasping for air

What makes your child's ability to breathe worse? (check all that apply)

☐ Colds/Viruses	☐ Exercise	☐ Crying/Upset	☐ Laughing too hard	☐ Mold
☐ Tobacco Smoke	☐ Chemicals	☐ Pollen	☐ Dust	
☐ Cold temperatures	☐ Change in weather	☐ Animals	☐ Cockroaches	
☐ Foods/Other (list):				

Is medication(s) taken at home?	☐ Yes – List:	☐ No
Is medication(s) needed while at school?	☐ Yes – Refer to Provider's Orders	☐ No
Is medication(s) needed during transport to/from school?	☐ Yes	☐ No

This page is to be completed by the Health Care Provider.

Child's Name: **Date of Birth:** **Gender:** ☐ M ☐ F

☐ **No medication is required at school (Skip box and sign below if you agree with this *Child Health Plan*).**

☐ **Medication is required at school (Fill out box and sign below). If medication is taken daily at home, a 3-day supply of medication is needed at school in case of a disaster.**

Health Care Provider Orders for Medication at School **Important notice to Provider:** Please ensure this child has a prescription on file with the pharmacy that matches the orders below. Our policy requires Health Care Provider Orders and medication labels to match exactly.		
1) Medication Name	**2) Symptoms for medication use**	
3) Dose	**4) Frequency & Length of time between doses**	**5) Route**
6) Possible side effects of medication		
7) Special administration and/or storage instructions		
8) If PRN, start date	**and end date**	**required.**

Health Care Provider Signature				**Date**			
Print Name				**Phone #**		**Fax #**	
Parent/Guardian Signature				**Date**			
Interpreter Signature				**Date**			
Nurse Consultant Signature				**Date**			
ITE/Teacher	**Date**	**ITP/Assistant**	**Date**	**FA/FE/FSS/HV**	**Date**	**Dir/C Coor**	**Date**