

# Asthma Health Care Plan

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**The following information should be completed by the child's health care provider.**

**Severity:**  Mild     Mild Persistent     Moderate Persistent     Severe Persistent

Check All Triggers		
<input type="checkbox"/> Cleaning Products	<input type="checkbox"/> Exercise	<input type="checkbox"/> Pet Dander
<input type="checkbox"/> Colds/Flu	<input type="checkbox"/> Food	<input type="checkbox"/> Smoke
<input type="checkbox"/> Cut Flowers, Grass, Pollen	<input type="checkbox"/> Odors/Fragrances	<input type="checkbox"/> Sudden Temperature Change
<input type="checkbox"/> Dust Mites	<input type="checkbox"/> Ozone Alert	
<input type="checkbox"/> Other: _____		

**Suggested classroom strategies to support this child's needs:**

\_\_\_\_\_

**Specific Medical Information:**

Medication to be administered:\*    Yes    No    If yes, medication to be administered and potential side effects:

\_\_\_\_\_

*\*For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the Medication Authorization form.*

Signs of medical distress:

\_\_\_\_\_

\_\_\_\_\_

Potential consequences to child if treatment is not administered: \_\_\_\_\_

\_\_\_\_\_

Staff Training Needs: \_\_\_\_\_

\_\_\_\_\_

Additional Emergency Procedures/Instructions (including when 911 should be called):

\_\_\_\_\_

\_\_\_\_\_

<b>If the child:</b> <ul style="list-style-type: none"> <li>• Is breathing regularly</li> <li>• Has no coughing or wheezing</li> <li>• Can engage in active play</li> </ul>	<b>What to do:</b> <ul style="list-style-type: none"> <li>• Allow current activity</li> </ul>	<b>Medication:</b> <ul style="list-style-type: none"> <li>• “As needed medication” not needed</li> <li>• Regular medication to be given as ordered</li> </ul>
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**CAUTION (Yellow Zone)**

<b>If the child has:</b> <ul style="list-style-type: none"> <li>• Early signs of a cold (runny nose, sneezing)</li> <li>• Exposure to a known trigger</li> <li>• Coughing</li> <li>• Mild wheezing</li> <li>• Chest tightness</li> </ul>	<b>What to do:</b> <ul style="list-style-type: none"> <li>• Cease current activity</li> <li>• If the child is outdoors bring inside</li> <li>• Observe breathing before and after the treatment (15 minutes)</li> </ul>	<b>Medication</b> <ul style="list-style-type: none"> <li>• Administer the “As needed medication” per the <u>Medication Authorization Form</u> and follow directions for use <ul style="list-style-type: none"> <li>• Monitor breathing status if no improvement follow the steps for the</li> </ul> </li> </ul>
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**DANGER (Red Zone)**

<b>If the child’s asthma is worse and any of the following apply:</b> <ul style="list-style-type: none"> <li>• The medications are not helping within 15-20 minutes of administration.</li> <li>• Breathing is becoming hard and fast</li> <li>• Nose (nostrils) open wide</li> <li>• Ribs are showing</li> <li>• Lips, fingernails or mouth area are blue or blue gray in color</li> <li>• Trouble walking or talking</li> </ul>	<b>What to do:</b> <ul style="list-style-type: none"> <li>• Call 911</li> <li>• Stay with the child—Stay calm</li> <li>• Ancillary staff notify the parent/guardian</li> <li>• Accompany the child to ER</li> <li>• Complete an Occurrence Report within 24 hours</li> </ul>	<b>Medication:</b> <ul style="list-style-type: none"> <li>• Medication available has already been given with no relief</li> <li>• Notify EMS staff regarding the type of medication and the time it was given.</li> </ul>
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**Parent/Guardian Acknowledgment Statement**

To ensure the safety of your child we cannot delete a health care diagnosis which has previously been documented unless we have a signed note from the child’s physician stating that the condition no longer exists; nor can we add an item(s) or change a medication without a signed note from the child’s physician.

I understand that Bright Horizons requires the most up to date information regarding my child’s health. I also understand that for the safety of my child, my child’s photograph and health information will be posted in the classrooms and kitchen.

<hr/> Physician Signature	<hr/> Date
<hr/> Parent/Guardian Signature	<hr/> Date
<hr/> Director/Principal Signature	<hr/> Date