

## Special Care Plan for a Child with Asthma

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Parent(s) or Guardian(s) Name:** \_\_\_\_\_

**Emergency phone numbers:** Mother \_\_\_\_\_ Father \_\_\_\_\_

*(see emergency contact information for alternate contacts if parents are unavailable)*

**Primary health provider's name:** \_\_\_\_\_ **Emergency Phone:** \_\_\_\_\_

**Asthma specialist's name (if any):** \_\_\_\_\_ **Emergency Phone:** \_\_\_\_\_

**Known triggers** for this child's asthma (circle all that apply):

colds	mold	exercise	tree pollens
house	dust	strong odors	grass flowers
excitement	weather changes	animals	smoke
foods (specify): _____			room deodorizers
other (specify): _____			

**Activities** for which this child has needed special attention in the past (circle all that apply)

<i>outdoors</i>	<i>indoors</i>
field trip to see animals	kerosene/wood stove heated rooms
running hard	art projects with chalk, glues, fumes
gardening	sitting on carpets
jumping in leaves	pet care
outdoors on cold or windy days	recent pesticides application in facility
playing in freshly cut grass	painting or renovation in facility
other (specify): _____	

Can this child use a **flowmeter** to monitor need for medication in child care?      NO      YES

personal best reading: \_\_\_\_\_ reading to give extra dose of medicine: \_\_\_\_\_

reading to get medical help: \_\_\_\_\_

How often has this child needed urgent care from a doctor for an attack of asthma:

in the past 12 months? \_\_\_\_\_ in the past 3 months? \_\_\_\_\_

**Typical signs and symptoms** of the child's asthma episodes (circle all that apply):

fatigue	face red, pale or swollen	grunting
breathing faster	wheezing	sucking in chest/neck
restlessness, agitation	dark circles under eyes	persistent coughing
complaints of chest pain/tightness	gray or blue lips or fingernails	
flaring nostrils, mouth open (panting)	difficulty playing, eating, drinking, talking	

### Reminders:

1. Notify parents immediately if emergency medication is required.

2. Get emergency medical help if.

- the child does not improve 15 minutes after treatment and family cannot be reached

- after receiving a treatment for wheezing, the child:

- |   |  |
|---|--|
| • is working hard to breathe or grunting                | • won't play                           |
| • is breathing fast at rest (>50/min)                   | • has gray or blue lips or fingernails |
| • has trouble walking or talking                        | • cries more softly and briefly        |
| • has nostrils open wider than usual                    | • is hunched over to breathe           |
| • has sucking in of skin (chest or neck) with breathing | • is extremely agitated or sleepy      |

3. Child's doctor & child care facility should keep a current copy of this form in child's record.

**Special Care Plan for a Child with Asthma (Continued)**

<b>Medications</b> for routine and emergency treatment of asthma for:			
_____		_____	
Child's name		Date of Birth	
<b>Name of medication</b>			
<b>When to use (e.g., symptoms, time of day, frequency, etc.)</b>	<i>routine or emergency</i>	<i>routine or emergency</i>	<i>routine or emergency</i>
<b>How to use (e.g., by mouth, by inhaler, with or without spacing device, in nebulizer, with or without dilution, diluting fluid, etc.)</b>			
<b>Amount (dose) of medication</b>			
<b>How soon treatment should start to work</b>			
<b>Expected benefit for the child</b>			
<b>Possible side effects, if any</b>			
<b>Date instructions were last updated by child's doctor</b>	Date: _____ Name of Doctor (print): _____ Doctor's signature: _____		
<b>Parent's permission to follow this medication plan</b>	Date: _____ Parent's signature: _____		

*If more columns are needed for medication or equipment instruction, copy this page*