

Health Care Plan

SEVERE ALLERGY TO:

Child's Name _____ Birth Date _____ Current Weight _____
Center _____ Classroom _____

EMERGENCY TREATMENT

For Mild Symptoms

- Several hives
- Itchy skin

OR If an ingestion (or sting) is suspected:

- Swelling at site of an insect sting

Treatment

1. **Contact** the parent/guardian or emergency contact person.
2. **Stay** with the child; keep child quiet, monitor symptoms until parent/guardian arrives.
3. **Watch** student for more serious symptoms listed below.

Special Instructions (for health care provider to complete):

Severe Symptoms can cause a Life Threatening Reaction

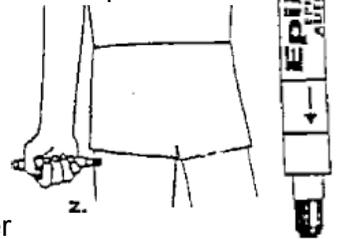
- Hives spreading over the body
- Wheezing, difficulty swallowing or breathing
- Swelling of face/neck, tingling or swelling of tongue
- Vomiting
- Signs of shock (extreme paleness/grey color, clammy skin)
- Loss of consciousness

Treatment

1. Use pre-measured EpiPen®/EpiPen® Jr. immediately, place against child's upper outer thigh, through clothing if necessary.
2. **CALL 911** (or local emergency response team) immediately.
*** 911 (emergency response team) should always be called if EpiPen®/EpiPen® Jr. is given.**
3. Contact parent/guardian or emergency contact person.
If parent/guardian unavailable, center staff should accompany the child to the hospital.

Directions for use of EpiPen®/EpiPen® Jr.:

1. Pull off grey cap.
2. Place black tip against child's upper outer thigh.
3. Press hard into outer thigh, until it clicks.
4. Hold in place 10 seconds, then remove.
5. Discard EpiPen®/EpiPen® Jr. in impermeable can. Dispose of per center policy, or give to emergency care responder. Do not return to holder.



Special Instructions (for health care provider to complete)

Prescribing Practitioner Signature _____

Date _____

Parent/Guardian Signature _____

Date _____

MEDICATION POLICY*

For Early Care and Education Centers and Family Child Care

Name:

Date:

PURPOSE:

This policy defines the requirements and procedures for administering medications to children enrolled in the _____.

Only authorized staff who have successfully completed a Medication Administration Training will administer medications.

Because administration of medication poses an extra burden for staff, and having medication in the facility is a safety hazard, families are asked whenever possible to arrange with their child's medical provider to schedule medications at times that do not include the hours the child is in the child care facility.

The first dose of any medication must be given at home to be sure that the child does not have an unexpected reaction to the medication.

Parents or guardians may administer medication to their own child during the child care day.

PROCEDURE:

Qualified Center staff will administer medications only if the parent or legal guardian:

- ▶ Has provided written consent.
- ▶ The medication is in the original prescription or over the counter container properly labeled.
- ▶ The Center has on file the written instructions of a health care provider for administration of the specific medication.

1. For prescription medications, parents or legal guardians must provide care givers with the medication in the original, child-resistant container that is labeled by a pharmacist with the child's first and last name; the name of the medication; the date the prescription was filled; the name of the health care provider who wrote the prescription; the medication's expiration date; and administration, storage and disposal instructions.
2. For over the counter medications, parents or legal guardians must provide the medication in the original container, labeled with the child's first and last name; specific, legible instructions for administration and storage; and the name of the health care provider who ordered the medication

3. Instructions for the dose, frequency, method to be used, and duration of administration must be provided to the child care staff in writing by a signed note or a prescription label. This requirement applies both to prescription and over the counter medications.
4. Children with recurring or ongoing health needs must have a health care plan with instructions from the prescribing physician for administration of specific medications based on need. The instructions must include the child's first and last name, the name of the medication; the dose; the method of administration; how often the medication may be given; the conditions for use; and any precautions to follow. Where required, staff must have additional, specific training and authorization to administer emergency or other special medications. (See additional information below specific to WV).
5. Medications and medication supplies must be stored in a clean, secure and locked area in a cool, dry place. This may be a locked strong box or cabinet that **is not within reach of children**. Medications requiring refrigeration must be kept in a secure, leak-proof container in a designated area of the refrigerator, if a separate refrigerator is not available.
6. Controlled substances such as Ritalin® shall be counted with the parent when received and then daily and documented on a log for that purpose, as per Center policy on Management of Controlled Medications.
7. Medications shall not be used beyond the date of expiration noted on the container or beyond any expiration of the instructions supplied by the prescribing health care provider. Expired medications will be returned to the parents or, if not collected within one week of expiration, flushed down the toilet. All disposed medications will be documented per Center policy on Disposal of Medications.
8. A medication log for each child will be maintained by the Center's designated Medication Administration Staff to record the instructions for giving medications; consent from the parent or guardian; amount, time and method of administration; the signature of the staff administering the medication; and any observations, comments related to administration of the medication. Spills, reactions and refusal to take medication will be noted on the log.
9. Medication errors will be handled and documented as per Center policy on Medication Errors, Injuries and Significant Incidents.

10. This policy will be reviewed annually and revised as needed.
Last review date:
Next review date:

* American Academy of Pediatrics, Model Child Care Health Policies, "Medication Policy" 4th Edition, September 2002 pg.7- 8.

** Additional training must be given to prepare staff in WV child care centers to provide specific, specialized care, not covered in this **basic** medication administration training course. This specialized training must be based upon the specific child's health care plan and be provided by parent/guardian or medical personnel familiar with the child's needs and the required procedure. Such training must not require medical/nursing judgment and must be consistent with WV Day Care Center Licensing Regulations (WV 78 CSR 1).

SCHEDULE OF CONTROLLED SUBSTANCES

The drugs and drug products that come under the jurisdiction of the Controlled Substances Act are divided into five schedules. Some examples in each schedule are outlined below. For a complete listing of all the controlled substances contact any office of the Drug Enforcement Administration. The examples of drugs in these schedules follow:

Schedule I Substances

The substances in this schedule are those that have no accepted medical use in the United States and have a high abuse potential. Some examples are heroin, marijuana, LSD, MDMA "ecstasy", peyote, mescaline, psilocybine, N-ethylamphetamine, acetylmethadol, fenethyline, and methaqualone.

Schedule II Substances

The substances in this schedule have a high abuse potential with severe psychic or physical dependence liability. Schedule II controlled substances consist of certain narcotic, stimulant and depressant drugs. Some examples of Schedule II narcotic controlled substances are: opium, morphine, codeine, hydromorphone (Dilaudid), methadone, pantopon, meperidien (Demerol), cocaine, oxycodone (Percodan), and oxymorphone (Desoxyn). Non-narcotic substances in Schedule II include: phenmetrazine (Preludin), methylphenidate (Ritalin), amobarbital, pentobarbital, secobarbital, fentanyl (Sublimze), sufentanil, etophine hydrochloride, phonylactone, dronabinol and adderall.

Schedule III Substances

The substances listed in this schedule have an abuse potential less than those in Schedules I and II, and include compounds containing limited quantities of certain narcotic drugs and non-narcotic drugs such as: codeine (Tylenol with Codeine), derivatives of barbituric acid except those listed in another schedule, nalorphine, benzphetamine, chlorphentermine, clortermine, phendimetrazine, paregoric and any compound, mixture, preparation or suppository dosage form containing amobarbital, secobarbital or pentobarbital.

Schedule IV Substances

The substances in this schedule have an abuse potential less than those listed in Schedule III and include such drugs as: barbitol, Phenobarbital, methylphenobarbital, chloral hydrate, ethchlorvynol (Placidyl), ethinamate (Valmid), meprobamate (Equanil, Miltown), paraldehyde, methohexital, fenfluramine, diethylpropion, phentermine, chlordiazepoxide (Librium), diazepam (Valium), oxazepam (Serax), clorazepate (Tranxene), flurazepam (Dalmane), clonazepam (Clonopin), prazepam (Verstran), alprazolam (Xanax), Halazepam (Paxipam), temazepam (Restoril), triazolam (Halcion), Lorazepam (Ativan), midazolam (Versed), Quazepam (Dormalin), mebutamate, dextropropoxyphene dosage forms (Darvon), and pentazocine (Talwin-NX).

Schedule V Substances

The substances in this schedule have an abuse potential less than those listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotic and stimulant drugs generally for antitussive, antidiarrheal, and analgesic (pain reduction) purposes. Some examples are bupremorphine and propylhexedrine; disphenoxylate and atropine (e.g., Lomotil); loperamide; and narcotic drugs in combination with other non-narcotic agents generally used as antitussives, where the amount of narcotic (e.g., codeine, dihydrocodeine) is limited.

MEDICATION CONSENT AND LOG*

Child's Name: _____

PARENT COMPLETE THIS SECTION

I give permission for child care staff to administer medication to my child as listed below:

CHILD CARE STAFF COMPLETE THIS SECTION

Date	Parent Signature	Name of Medication	To Be Given		Dose/Route	Refrige rate	Date	Safety Check	Time Given	Staff Signature	Comments
			Date	Time							

Safety Check:

1. Child resistant container
2. Name of child on container
3. Name and phone number of health care provider who ordered medication
4. Original prescription or manufacturer's label and health provider's directions for use
5. Current date on prescription/expiration label

*AAP – Model Child Care Policies – Appendix Q

FORM #1
PERMISSION TO ADMINISTER OVER THE COUNTER MEDICATIONS IN CHILD CARE
***(Use one form for each medication)**

Form to be completed by the child's health care provider:

Child: _____ Birthdate: _____

Medication: _____

Dosage: _____ Route: _____

Time of day medication to be given: _____

Special Instructions: _____

Purpose of Medication:

Possible Side Effects:

Start Date:

End Date:

Signature of Health Provider with Prescriptive Authority: _____

Phone # _____

Date: _____

To be completed by parent or guardian:

I hereby give my permission for _____ to take the above medication in child care, as ordered by the health care provider. I understand that it is my responsibility to furnish this medication.

Signature of parent/legal guardian _____ Date: _____

Note: The medication is to be brought to the child care center in the original container which clearly states the child's name, the health care provider, the name of the medication, date, time and dosage and route. This form must also be filled out completely in order for the medication to be given.

FORM #2

**MEDICATION ADMINISTRATION
Instructions for Health Care Provider**

Medication will be administered by Staff of _____ only when this form is completed and signed by the child's health care provider and parent/guardian.

Parent/guardian **must** administer the initial dose of ALL medications, **not** child care staff.

Over the counter, non-prescription medications must follow the same procedure as prescription medications.

**HEALTH CARE PROVIDER
Please provide the following information**

Child's first and last names: _____

Medical Condition being treated: _____

Medication: _____

Dosage: _____ Frequency/Time: _____ Route: _____

Duration of Treatment: (use dates) From: _____ To: _____

Comments or Specific Instructions: _____

Health Care Provider Signature

Date

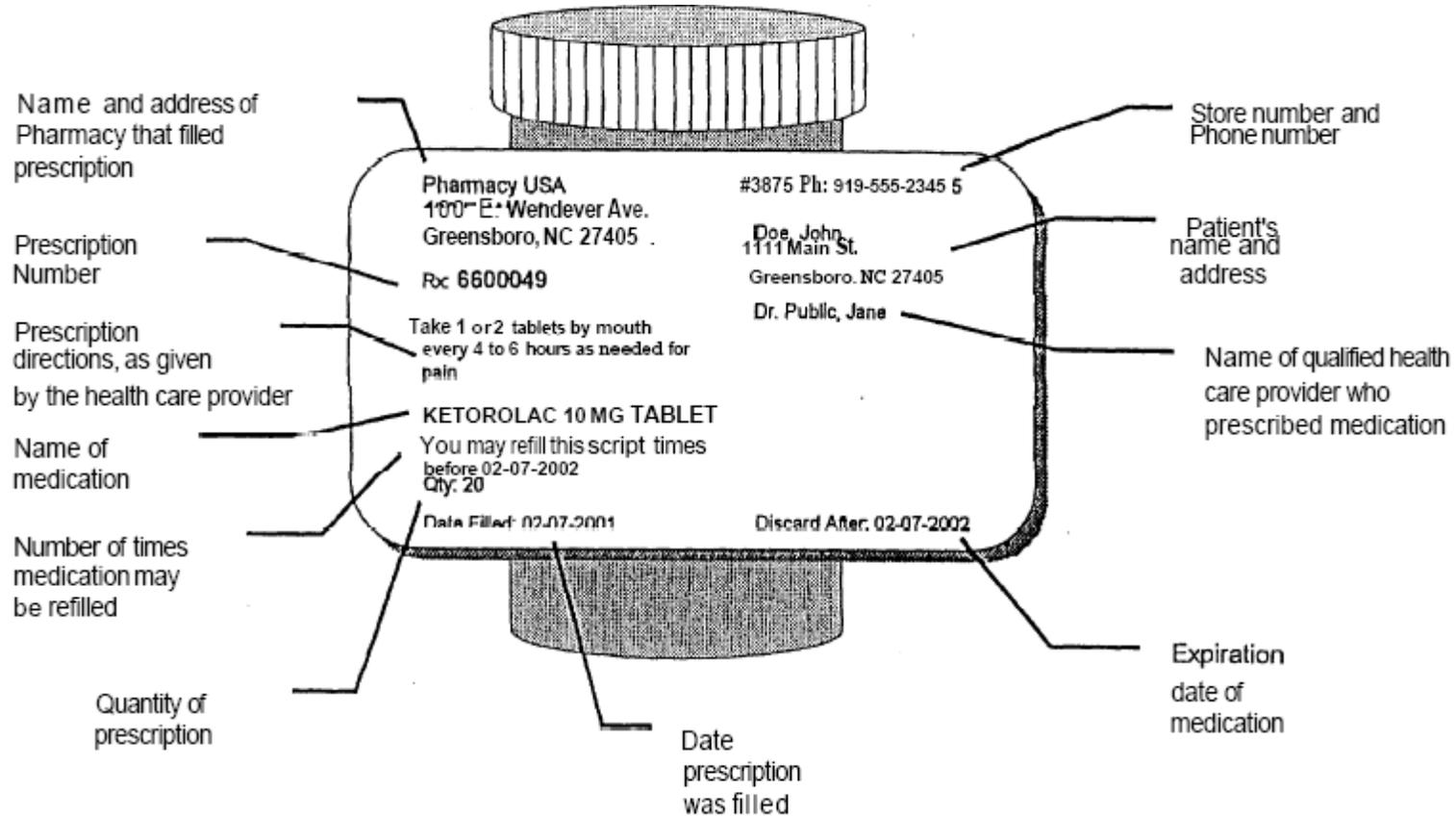
Health Care Provider's Name: _____

[Please Print] Address: _____

Parent/Guardian Signature

Date

What's on a Prescription Label?



Non-Prescription (OTC) WHAT'S ON THE NEW LABEL

All nonprescription, over-the-counter (OTC) medicine labels have detailed usage information so consumers can properly choose and use the products.

Below is an example of what the new OTC medicine label looks like.

ACTIVE INGREDIENT
Therapeutic substance in product; amount of active ingredient per unit

USES
Symptoms or diseases the product will treat or prevent

WARNINGS
When not to use the product; conditions that may require advice from a doctor before taking the product; possible interactions or side effects; when to stop taking the product and when to contact a doctor; if you are pregnant or breastfeeding, seek guidance from a health care professional; keep product out of children's reach

INACTIVE INGREDIENTS
Substances such as colors or flavors

PURPOSE
Product action or category (such as an antihistamine, antacid, or cough suppressant)

DIRECTIONS
Specific age categories, how much to take, how to take, and how often and how long to take

OTHER INFORMATION
How to store the product properly and required information about certain ingredients (such as the amount of calcium, potassium, or sodium the product contains)

The new Drug Facts labeling requirements do not apply to dietary supplements, which are regulated as food products, and are labeled with a Supplement Facts panel.

Drug Facts
Chlorpheniramine maleate 2 mg

Active ingredient (in each tablet)
Chlorpheniramine maleate 2 mg

Purpose
Antihistamine

Uses
temporarily relieves these symptoms due to hay fever or other upper respiratory allergies: sneezing, runny nose, itchy, watery eyes, itchy throat

Warnings
Ask a doctor before use if you have:
glaucoma, a breathing problem such as emphysema or chronic bronchitis, trouble urinating due to an enlarged prostate gland.
Ask a doctor or pharmacist before use if you are taking tranquilizers or sedatives.
When using this product:
you may get drowsy; avoid alcoholic drinks; alcohol, sedatives, and tranquilizers may increase drowsiness; be careful when driving a motor vehicle or operating machinery; excitability may occur, especially in children.
If pregnant or breast-feeding, ask a health professional before use. Keep out of reach of children. In case of overdose, get medical help or contact a Poison Control Center right away.

Directions
adults and children 12 years and over: take 2 tablets every 4 to 6 hours; not more than 12 tablets in 24 hours.
children 6 years to under 12 years: take 1 tablet every 4 to 6 hours; not more than 6 tablets in 24 hours.
children under 6 years: ask a doctor.

Other information
store at 20-26°C (68-77°F); protect from excessive moisture.
Inactive ingredients: D&C yellow No. 10, lactose, magnesium stearate, microcrystalline cellulose, pregelatinized starch.

THE SEVEN RIGHTS OF MEDICATION ADMINISTRATION

These seven rights are a safety check to help reduce the chance of making a mistake in medication administration.

1. **RIGHT CHILD - Protect Confidentiality**
 - < Is this the right child? Double Check, even if you think you know the child to whom you're giving the medication
 - < Check the name on the medication label against the permission form
 - < Confirm the child's identity with another person
 - < Ask the child his name
 - < Verify the child's identity with the child's picture if available

2. **RIGHT MEDICATION**
 - < Medications must be given from a properly labeled original bottle
 - < Compare the prescribing practitioner's written authorization form to the pharmacy label and medication log
 - < Read the label three times
 - < First, when it is removed from the secured cabinet
 - < Second, when the medicine is poured
 - < Third, when returning the medication to the secured cabinet

3. **RIGHT DOSE**
 - < Give the exact amount of medicine specified by the order from the health care provider and pharmacy label
 - < Use standard measuring devices for medications
 - < **Do Not Use Kitchen Utensils.** These do not provide accurate measurements
 - < 1 milliliter = 1 cc
 - < 5 milliliters or 5 cc = 1 teaspoon

4. **RIGHT TIME**
 - < Check with the parent/guardian the time when the medication was last given at home
 - < Check the medication log for the time the medicine needs to be given by child care staff
 - < Check to see if the medicine has already been given for the current day or dosage
 - < Plan to give medication at time ordered; Up to 30 minutes before or 30 minutes after the time scheduled is allowed before it is considered a medication error

5. **RIGHT ROUTE**
 - < Check the medication order and the pharmacy label for the route the medication is to be given e.g., by mouth, inhaled, ear drops, eye drops, topical

6. **RIGHT REASON**
 - < Check that medication is being given for right reason (e.g. cough preparation for cough, Tylenol® for fever).

7. **DOCUMENTATION**
 - < Maintain a record of all medication administered to children
 - < Document only medication you have administered
 - < Administer only medication you have prepared
 - < Remember

IF IT ISN'T WRITTEN - IT DIDN'T HAPPEN

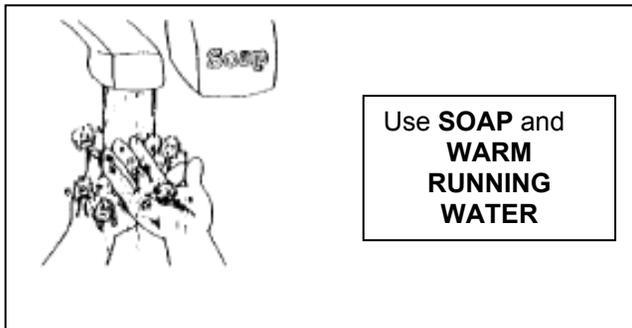
TRIPLE CHECK THESE SEVEN R'S EVERY TIME YOU GIVE MEDICATION

THE

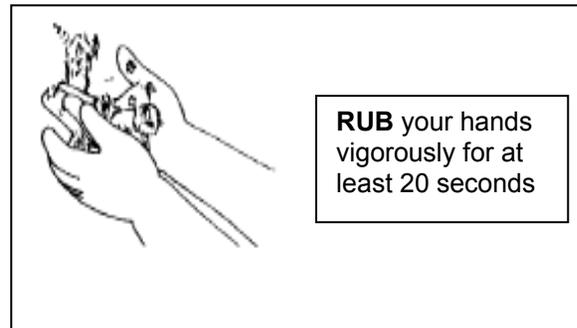


METHOD OF HANDWASHING

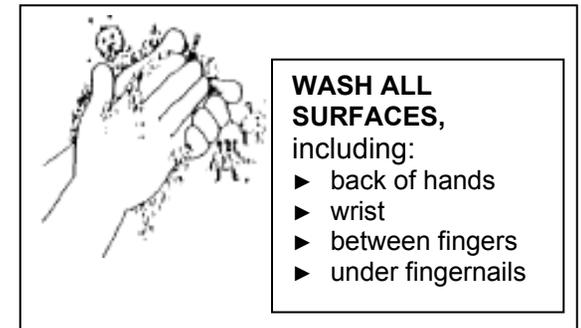
(Young Children may need adult supervision when washing their hands)



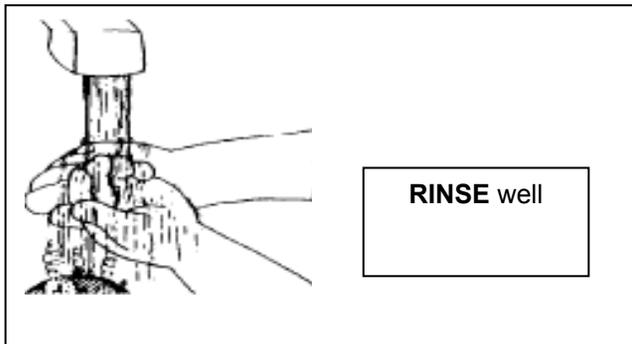
Use **SOAP** and
WARM
RUNNING
WATER



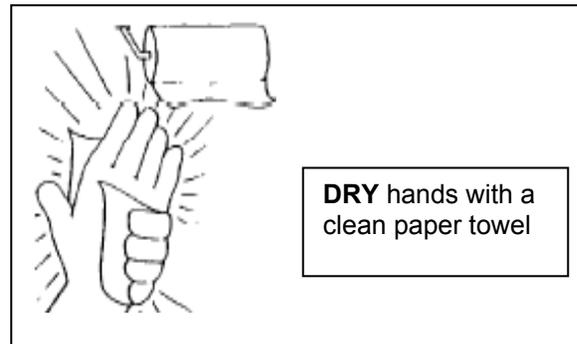
RUB your hands
vigorously for at
least 20 seconds



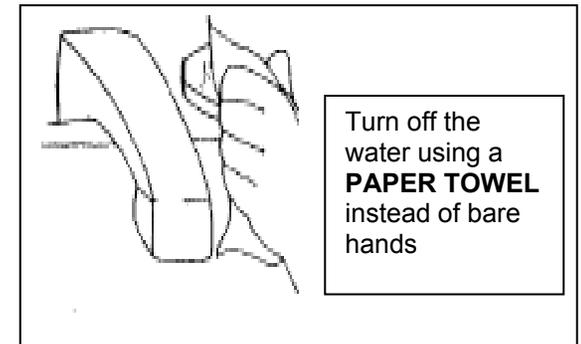
WASH ALL SURFACES,
including:
▶ back of hands
▶ wrist
▶ between fingers
▶ under fingernails



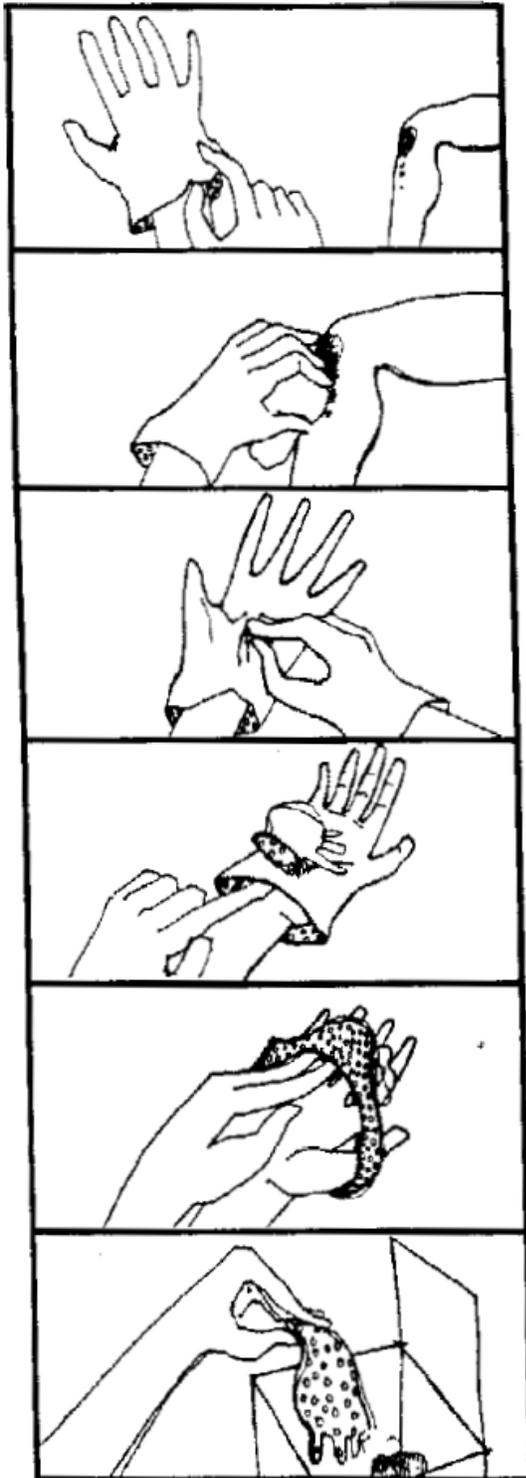
RINSE well



DRY hands with a
clean paper towel



Turn off the
water using a
PAPER TOWEL
instead of bare
hands

Gloving

Put on a clean pair of gloves.

Provide the appropriate care.

Remove each glove carefully. Grab the first glove at the palm and strip the glove off. Touch dirty surfaces only to dirty surfaces.

Ball-up the dirty glove in the palm of the other gloved hand.

With the clean hand strip the glove off from underneath at the wrist, turning the glove inside out. Touch dirty surfaces only to dirty surfaces.

Discard the dirty gloves immediately in a step can. Wash your hands.



UNIVERSAL PRECAUTIONS



Tools for Administering Liquid Medications



Syringe



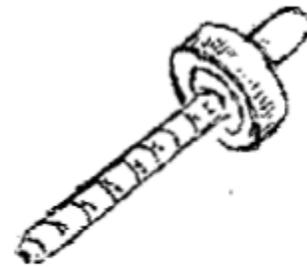
Calibrated
Medicine Cup



Nipple
(permissible for
administering but
not for measuring)

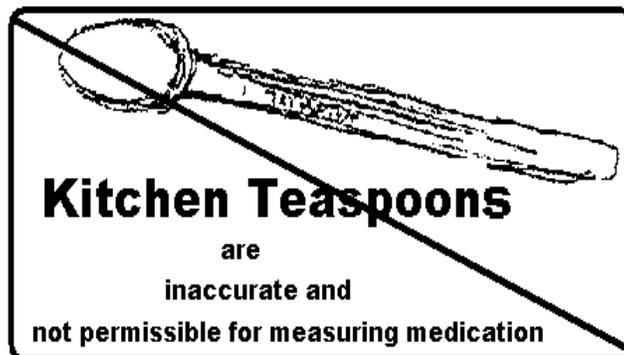


Calibrated Spoon



Calibrated Dropper

NO



Kitchen Teaspoons
are
inaccurate and
not permissible for measuring medication

NO

Using Pre-measured EpiPen®/EpiPen® Jr.

In the event of anaphylaxis, an allergic reaction that may be triggered by **asthma**, an **insect bite**, a **medication allergy**, or a **food allergy**, pre-measured **EpiPen®/EpiPen® Jr.** would be used **ONLY** for the **child for whom it was prescribed**. In addition, this **child would also have an individual health care plan** as well as **parent/guardian's written permission** on file.

Allergic Reactions

Mild symptoms may include

Rash
Itching
Hives

Moderate symptoms may include above plus

Breathing difficulty
Wheezing

Severe symptoms may include above plus

(Anaphylactic shock)
Severe breathing difficulty
Shock (vascular collapse)
Laryngeal swelling (throat closing)
Cardiac arrest

If any of the above symptoms occur:

1. **Call 911.** Call for staff to assist with child and/or to call parent/guardian.
2. **Get EpiPen®/EpiPen® Jr.** Put on disposable gloves if available.
3. **Remove protective covering** of EpiPen®/EpiPen® Jr. (auto-injector).
4. **Give child quick explanation** of what you are going to do.
5. Have assistant **help hold child securely**.
6. Make a **fist around the auto-injector** with **black tip facing down**.
7. **DO NOT REMOVE THE SAFETY CAP UNTIL READY TO USE THE AUTO-INJECTOR.**
8. **Pull off gray safety cap.**
9. **Once gray cap is removed, auto-injector is ready for use.**
10. **NEVER PUT YOUR FINGERS OVER THE BLACK TIP WHEN REMOVING THE SAFETY CAP OR AFTER SAFETY CAP HAS BEEN REMOVED.**
11. Place **black part of syringe** against skin of child's upper outer thigh, through clothing if necessary.
12. **DO NOT PUT YOUR THUMB OVER THE END OF AUTO-INJECTOR.**
13. **Press hard** (holding at 90 degree angle to skin) until you **hear a click** at which point the auto-injector releases the medication.
14. At this point, **child will feel a pinch**.
15. **Keep auto-injector in place for count of 10** so that all medication is delivered.
16. **Remove and massage area for 10 seconds—apply band aide.**
17. **Dispose of entire auto-injector** in coffee can or give to EMS staff.
18. **Document medication** was given on medication administration log or Emergency Medication Sheet (if used in center).
19. **If parent/guardian unavailable, accompany child to hospital/clinic.**
20. **Remind parent/guardian—must provide “new” EpiPen®/EpiPen® Jr. for child.**

RECORD OF EMERGENCY MEDICATION ADMINISTRATION

Child's name _____ Parent/guardian name _____

Allergies _____ Phone (home) _____

Date _____ Phone (work) _____

Time of occurrence _____

Symptoms _____

Medication/s administered _____ Dose _____

Route _____

If pre-measured EpiPen®/EpiPen® Jr., location where injection was given.

Time _____ 911 called _____ Parent/guardian called _____
(time) (time)

Side effects

Disposition of child (e.g. taken by ambulance to hospital/clinic, etc.)

Signature _____ Date _____

MEDICATION ERROR REPORT*
(SERIOUS OCCURRENCE REPORT)

Name of Facility: _____ Date of Report: _____

Name of person completing report: _____

Signature of person completing report: _____

Child's Name: _____

Date of Birth: _____ Classroom: _____

Date error occurred: _____ Time noted: _____

Person administering medication: _____

Prescribing health care provider: _____

Name of Medication: _____

Dose: _____ Scheduled Time: _____

Route: _____

Described error and how it occurred:

Action taken/intervention:

Parent/Guardian notified: Y____ N____ Date: _____ Time: _____

Name of parent/guardian notified: _____

Follow-up and Outcomes: _____

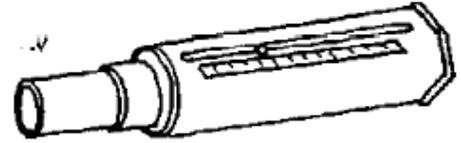
Signature Center/Program Director: _____

Actions taken to prevent repeat error:

✂ THE PEAK FLOW METER: When and How to Use One ✂

What is a Peak Flow Meter?

The *peak flow meter* measures how fast the student can blow air out through the airways. It lets the student and supervising adult know how much airway narrowing is present at a given time. There are many different types of peak flow meters, but they all do the same thing.



How Can a Peak Flow Meter Help?

- It can tell how much airway narrowing is present.
- It can give early warning of an asthma episode, sometimes before symptoms develop.
- It can signal when medication can prevent worsening asthma.
- It can measure how well the student's asthma medications are working.
- It can help identify asthma as the cause of shortness of breath, chest tightness, coughing, or fatigue during physical activities (P.E., recess, sports).
- It can help adults share information about the student's asthma.

Which Student Should Have a Peak Flow Meter at School?

- If the student requires asthma medications at school, it is also helpful to have a peak flow meter available.
- The student who has asthma symptoms at school.

The school nurse should talk with the student's family and physician about having a peak flow meter at home and another at school.

How is a Peak Flow Meter Used?

Give the student the following instructions:

- Stand up straight and make sure the pointer is at "zero" on the meter. Clean out your mouth (gum, food, etc.).
- Take a deep breath. Put the mouthpiece past your teeth and close lips around it. Make sure your tongue doesn't touch the mouthpiece.
- Blow out as **hard and fast** as you can. A fast blast, not a slow blow.
- Check to see how high the pointer went. This value is the "peak flow."
- Repeat two more times and write down the highest peak flow of the three blows. Most school-aged children can use a peak flow meter correctly with practice.



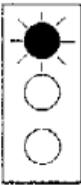
When is the Peak Flow Meter Used?

- Before P.E. or physical activities (e.g., "field day").
- On or before field trips.
- During asthma episodes. A peak flow measure ~will help to guide asthma care (see the "Asthma Health Care Plan").
- Whenever there is any question about chest symptoms or asthma control.

What do Peak Flow Readings Mean? _____

The peak flow reading should be compared to the student's "Personal Best" peak flow value: The student can blow his/her "Personal Best" when asthma is well-controlled. The student's physician should determine the student's "Personal Best" peak flow value. This *Personal Best value should be clearly recorded in the student's health file and used to make asthma management decisions* (see the "Asthma Health Care Plan").

It is helpful to think about peak flow "zones":

	GREEN ZONE <ul style="list-style-type: none">• 80-100% of the student's "Personal Best"• Asthma <i>is</i> under good control.
	YELLOW <ul style="list-style-type: none">• 50-80% of the student's "Personal Best"• CAUTION - Asthma <i>is not</i> under good control. Additional steps need to be taken.
	RED ZONE <ul style="list-style-type: none">• LESS THAN 50% of the student's "Personal Best"• DANGER - immediate action is needed.• Give treatment as directed by the student's physician (see the "Asthma Health Care Plan").• If the response <i>is poor</i>, call 9-1-1 or emergency medical services in your area. The student should be taken <i>urgently</i> to the emergency room.• Call the parent/guardian.

How to Help the Student's Physician Set Peak Flow Zones _____

- Have the student see the school nurse two times per day, if possible. If only one time is possible, morning is preferable. This can be around medication time, but not after exercise.
- Have the student blow a peak flow three times and record the best number. Remember, the student must blow as hard as possible.
- If the student takes an inhaled bronchodilator, have the student repeat the peak flow about five to ten minutes after the medication. Record this best peak flow value too.
- Repeat this for two consecutive weeks. The student's asthma needs to be stable and well controlled during this time.
- You should now have a narrow range of peak flow values. This information should be shared with the student's physician for setting the student's "Personal Best" value and Green-Yellow-Red Zones. These values will allow you to better assess the student.
 - Peak flow values are affected by age, height, race, and sex. Keep in mind that if the student is growing, their "personal best" is also likely to increase.

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as _____
 or has a peak flow reading at or below _____

Child is allergic to: _____

Steps to take during an asthma episode:

1. Check peak flow reading (if child uses a peak flow meter).
2. Give medications as listed below.
3. Check for decreased symptoms and/or increased peak flow reading.
4. Allow child to stay at child care setting if: _____
5. Contact parent/guardian
6. See emergency medical care if the child has any of the following:

Steps to take during an allergy episode:

1. If the following symptoms occur, give the medications listed below.
2. Contact Emergency help and request epinephrine.
3. Contact the child's parent/guardian.

Symptoms of an allergic reaction include:

(Health Care Provider, please circle those that apply)

- No improvement minutes after initial treatment with medication.
- Peak flow at or below _____
- Hard time breathing with:
 - ▶ Chest and neck pulled in with breathing.
 - ▶ Child hunched over.
 - ▶ Child struggling to breathe.
- Trouble walking or talking.
- Stops playing and cannot start activity again.
- Lips or fingernails are gray or blue.

**IF THIS HAPPENS,
 GET EMERGENCY
 HELP NOW!**

- Mouth/Throat: itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
- Skin: hives; itchy rash; swelling
- Gut: nausea; abdominal cramps; vomiting; diarrhea
- Lung*: shortness of breath; coughing; wheezing
- Heart: pulse is hard to detect; "passing out"
- *If child has asthma, asthma symptoms may also need to be treated.

Emergency Asthma Medications:

	Name	Amount	When to Use
1			
2			
3			
4			

Emergency Allergy Medications:

	Name	Amount	When to Use
1			
2			
3			
4			

Special Instructions:

Special Instructions:

 Health Care Provider Signature Date

 Parent/Guardian's Signature Date

 Child Care Provider's Signature Date

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)

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

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

**Medication Administration in School or Child Care
Nebulizer Treatments or Inhaled Medications**

Parent or Guardian Permission

The parent/guardian of _____ ask that school/child care staff give the following medication _____ at _____
(Name of medicine and dosage) (Time)

to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

- ▶ The Program agrees to administer medication prescribed by a licensed health care provider.
- ▶ It is the parent/guardian responsibility to furnish the medication and equipment and to keep daily emergency contact information up to date.

By signing the document, I give permission for my child's health care provider/clinic to share necessary information regarding the care of my child's health condition with Program staff.

Parent/Legal Guardian's Name

Parent/Legal Guardian Signature

Date

Home Phone

Work Phone

Health Care Provider Authorization

Child's Name _____ Birthdate: _____

Name of inhaled medication: _____

Dosage: _____

To be given in school/child care at the following time(s): _____

Note to health care provider: Specific time and/or interval must be indicated on this form in order for non-medical persons in school/child care to administer medication

Start Date: _____ End Date: _____

Usual (baseline) respiratory rate for this child: _____

Comments: _____

Seek Emergency Medical Care if the child has any of the following:

- ▶ Respiratory rate greater than _____
- ▶ Coughs constantly
- ▶ Hard time breathing with:
 - T Chest and neck pulled in with each breath
 - T Struggling or gasping for breath
- ▶ Trouble walking or talking
- ▶ Lips or fingernails are grey or blue
- ▶ Other

Signature of Health Care Provider with Prescriptive Authority

Phone

NEBULIZER TREATMENT LOG

Center _____

Child's Name _____

Classroom _____

Medication and dosage 1. _____

Time(s) to be given _____

2. _____

Start date _____ End date _____

Special Instructions: _____

Daily reminder: Ask the parent/guardian the time of the last treatment. Nebulizer treatments should not be given more than every 4-6 hours. Be sure to follow written instructions provided by the health care provider.

Date	Time	Breath rate per minute: before	Breath rate per minute: after	Observations (Cough, skin color, secretions, any discomfort, activity level, etc.)	Staff Initials

Comments:

Staff Signature and Initials: _____

Normal breathing rate at rest:

Infant < one year: 20-40 breaths/minute

Toddler: 18-30 breaths/minute

School age child: 16-25 breaths/minute



STEPS TO FOLLOW DURING AN ASTHMA EPISODE



1. Give medication as listed in **Asthma Health Care Plan**.
2. Encourage child to relax with slow deep breaths.
3. Offer sips of warm water to relax and refocus the child's attention.
4. **Contact parent/guardian** if no improvement after 15-20 minutes.
5. **See emergency medical care or call 9-1-1** if the student has any of the following:
 - No improvement 15-20 minutes after initial treatment with medication and a emergency contact person cannot be reached.
 - Difficulty breathing with:
 - chest and neck "pulling in" with breathing
 - child is hunched over
 - child is struggling to breathe
 - Trouble walking or talking
 - Stops playing and can't start activity again due to breathing difficulties.
 - Lips or fingernails turn gray or blue
 - Decreasing or loss of consciousness