Asthma/Reactive Airway Disease (RAD) Individual Child Care Plan

Child's Name: ______________________ Date of Birth: ___/___/___
Allergies: ______________________

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: ______________________
Name Home # Work # Other

Parent/Guardian #2: ______________________
Name Home # Work # Other

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

Primary health provider's name: ____________ **emergency phone**: ________
Asthma specialist's name (if any): ____________ **emergency phone**: ________

TO BE COMPLETED BY HEALTHCARE PROVIDER

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

colds	tree pollens	grass	aerosol sprays	mold
powder/chalk dust	weather changes	animals	flowers	exercise
strong odors	room deodorizers	smoke	house dust	excitement

foods (specify) ______________________
other (specify) ______________________

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

Outdoors	*Indoors*
field trips to see animals/farms	kerosene/wood stove heated rooms
running hard	art projects with chalk, glues, fumes
gardening, jumping in leaves	pet care
outdoors on cold or windy days	recent pesticide application in facility
playing in freshly cut grass	painting or renovation in facility
other (specify) ____________	sitting on carpets

Special considerations: related to his/her asthma while at the program? (Check any that apply and describe briefly.)

- ☐ Modified physical activities ______________________
- ☐ Modified outdoor times or activities ______________________
- ☐ No animal pets in classroom ______________________
- ☐ Avoiding certain foods ______________________
- ☐ Emotional or behavior concerns ______________________
- ☐ Special consideration while of field trips ______________________
- ☐ Observation for side effects from medication (see back page).
- ☐ Need to take medication while at the program (see back page).
- ☐ Other______________________

Can this child use a **flowmeter** to monitor need for medication in child care? ___ Y ___ N
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? ____________

Special physician/parents orders: ______________________

Medications (routine and emergency): See back page

- Over -

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
     - is breathing fast at rest (>50/min)
     - won't play
     - is hunched over to breathe
     - is extremely agitated or sleepy
     - has sucking in of skin (chest or neck) with breathing
     - cries more softly and briefly
     - has gray or blue lips or fingernails
     - has trouble walking or talking
     - has nostrils open wider than usual
3. *The child's doctor and the child care facility should keep a current copy of this form in the child's file.*

Medications for routine and emergency treatment of asthma for ______________________ **(child's name)**

Name of Medication				
When to use give specific symptoms (i.e.: coughing, cold symptoms, wheezing, respiratory rate of ____ per minute)				
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				

Physicians Signature: ______________________________ Date: ____/____/____

Parent/Guardian Signature: ______________________________ Date: ____/____/____

TRAINED CHILD CARE PROVIDERS:

1. ______________________________ Room: ____________________

2. ______________________________ Room: ____________________

Plan of care reviewed by:

Director: ______________________________ Date: ____/____/____

Teacher: ______________________________ Date: ____/____/____

Child Care Health Consultant: ______________________________ Date: ____/____/____

Projected date of plan re-evaluation (every six months or sooner if needed): Date: ____/____/____

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