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

Child's Name: _____ Date of Birth: _____

Allergies: _____ Reason for Prescribing: _____

EMERGENCY PHONE NUMBERS

	Name	Home #	Work #	Other
Parent/Guardian #1:				
Parent/Guardian #2:				

(see emergency form 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):

Are there any **activities** for which this child has needed special attention in the past?

- ☐ Colds
- ☐ Powder/chalk dust
- ☐ Strong odors
- ☐ Tree pollens
- ☐ Weather changes
- ☐ Room deodorizers
- ☐ Grass
- ☐ Animals
- ☐ Smoke
- ☐ Flowers
- ☐ House dust
- ☐ Aerosol sprays
- ☐ Mold
- ☐ Exercise
- ☐ Excitement
- ☐ Foods: _____
- ☐ Other: _____

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

- ☐ Modified physical or outdoor activities _____
- ☐ Emotional or behavior concerns _____
- ☐ Avoiding Certain Foods/Other _____
- ☐ How often has this child needed urgent care from a doctor for an attack in the past six months? _____
- ☐ Special physician/parent's orders: _____

Please complete medication information on back page.

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

Medications for treatment of asthma/RAD for (Child's Name): _____

Name of Medication **to be given at ECC**:			
When to use, give specific symptoms (i.e. coughing, cold symptoms, wheezing)			
How to use (e.g. by mouth, by inhaler, with or without spacer, in nebulizer, with or without dilution, etc.)			
Amount (dose) of medication			
How soon treatment should start to work			
Expected benefit for the child			
Possible side effects, if any			

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 **OR**
   ~if (after treatment) child is working hard to breathe, grunting, refusing to play, flaring nostrils while breathing, having trouble walking or talking, has blue/gray lips or fingernails, is extremely agitated or sleeping, has sucking in of skin (on chest or neck) with breathing.
3. The child's doctor and the child care facility should keep a current copy of this form in the child's file.

Physician's 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: _____

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