

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 medical provider and parent/guardian.

Severity: Mild Mild Persistent Moderate Persistent Severe Persistent

Check all triggers: (completed by child's medical provider)

- Smoke (cigarette) Colds/flu Dust mites Exercise: _____
- Sudden temperature changes Ozone Alert Pet dander Strong
- Odors _____ Wood smoke Cut flowers, grass or pollen
- Mold Food: _____
- Cleaning Products: _____
- Others: _____

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.*

Potential consequences to child if treatment is not administered: _____

Special Staff Training Needs: _____

Additional Emergency Procedures/Instructions: _____

GO (Green Zone)

The child is able to do all of these: <ul style="list-style-type: none"> Breathing is regular No cough or wheeze Can engage in active play 	What to do: <ul style="list-style-type: none"> Allow current activity 	Medication: <ul style="list-style-type: none"> "As needed medication" not needed at this time Regular medication should be given as ordered
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CAUTION (Yellow Zone)

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

<p>The child’s asthma is worse and any of the symptoms are seen:</p> <ul style="list-style-type: none"> • The medications are not helping within 15-20 minutes of being given. • Breathing is becoming hard and fast • Nose (nostrils) open wide • Ribs are showing • Lips, fingernails or mouth area are blue or blue gray in color • Trouble walking or talking 	<p>What to do:</p> <ul style="list-style-type: none"> • Activate EMS (emergency medical services) • Stay with the child—Stay calm • Ancillary staff notify the parent/guardian • Accompany the child to ER • Complete an <u>incidence form</u> within 24 hours 	<p>Medication:</p> <ul style="list-style-type: none"> • Medication available has already been given with no relief • Notify EMS staff regarding the type of medication and the time it was given.
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For MA centers only:

Staff may be trained by: _____

The following staff have been trained on the child’s medical condition:

_____	_____
_____	_____

Physician Signature

Date

Parent/Guardian Signature

Date

Director/Principal Signature

Date

Parent/Guardian Acknowledgement 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.

Parent/Guardian Signature: _____

Date: _____

This plan must be updated annually or whenever there is any change in treatment or the child’s condition changes.