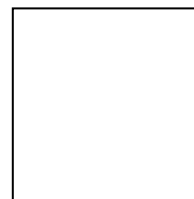


Care Plan for Asthma



Name of Student: _____

Attach picture of child.

Parent Names: _____ Parent Emergency Phone: _____

Primary Care provider: _____ Emergency Phone: _____

Asthma specialist's name: _____ Emergency Phone: _____

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

colds	mold	exercise	tree pollens
house	dust	strong odors	grass
excitement	weather changes	animals	smoke
room deodorizers	leaves	flowers	

Food (specify) _____

Other (specify) _____

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

Outdoors	Indoors	
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) _____		

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
 - a. The child does not improve 15 after treatment and family cannot be reached
 - b. After receiving a treatment fo wheezing, the child:

*is working hard to breathe or grunting	*won't play
*is breathing fast at rest	*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	

Asthma Care Plan for _____

Date of birth _____

Medications for routine and emergency treatment of asthma

Name of Medication	#1	#2	#3
When to use (e.g. symptoms, time of day, frequency, etc.)	Routine or emergency	Routine or emergency	Routine or emergency
How to use (e.g. by mouth, by inhaler, with or without spacer 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 _____		

Check all that apply.

_____ Medication will be kept in the classroom Emergency Backpack.

_____ Teachers may administer medication at school. (Parent will train staff in use of medication.)

_____ Call parents immediately so they can arrive at school and give needed medication.