# Asthma Care Plan

Emergency Plan for: _____

Facility Name: _____ Facility Address: _____

Child's Full Name:

Date of Birth:

Parent/Guardian:

Phone (home/cell): Phone (work):

Emergency Contact:

Phone (home): Phone (work):

Primary Care Provider: Office Phone:

**Picture ID**

## CHILD'S ASTHMA TRIGGERS ARE:

☐ change in temperature ☐ colds, infection ☐ dust, mites ☐ emotion (e.g. upset) ☐ mould ☐ physical activity ☐ pollen

☐ animals (list): _____

☐ foods (list): _____

☐ strong smells (list): _____

☐ Other: _____

## CHILD'S ASTHMA SYMPTOMS ARE USUALLY:

☐ appears anxious
☐ coughing
☐ difficulty talking
☐ fast/shallow breathing
☐ pale
☐ hunched over
☐ short of breath
☐ wheezing
☐ in-drawing/tracheal tug
☐ other (list below):
☐
☐

## CHILD'S EMERGENCY TREATMENT:

☐ Medication are:

☐ Medication is stored:

☐ Medication expiry date:

☐ Names of staff oriented to plan:

☐ Emergency plan review date (to do yearly):

☐ Field Trip Plans:

- **GIVE** _____
  (name of medication)
- **Follow Instructions:**

- **If unsure, child is worse or not getting better CALL 911**
- **CALL PARENTS**

*It is the parent's responsibility to notify the facility of any change in the child's condition.*

Sign below if you agree with above Information & Plan:

Primary Care Provider _____ Date _____

Parent/Guardian _____ Date _____

Childcare Supervisor/School Personnel _____ Date _____

Asthma Care Plan is provided as a resource from Vancouver Coastal Health – February 2011

Vancouver CoastalHealth
Promoting wellness. Ensuring care.