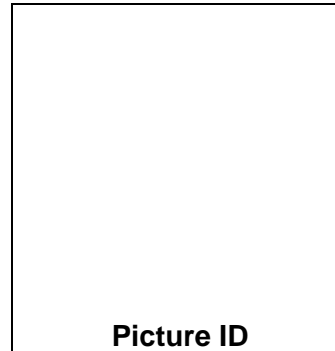


Asthma Care Plan
Facility Name: _____

Emergency Plan for: _____
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: _____



• **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

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

CHILD'S EMERGENCY TREATMENT:

Medication is: _____
 Medication is stored: _____
 Medication expiry date: _____
 Names of staff oriented to plan: _____
 Emergency plan review date (to do yearly): _____

Field Trip Plans: