Plan of Care for Asthma

Child's Name:_____Date of Birth:_____Age:____
Program Site:_____ School Year_____

Medications your student uses for asthma:
*(*Please list medications for Emergency treatment of an asthma attack on next page.)*

Name of Medication	Dosage	Time of day given

Would any of the above medication(s) need to be given during program hours? ___Yes* ___No
If yes, a medication form must be filled out by the physician and returned **before your student can receive any medication.* *Medication must be in original container with correct dosage instructions.*
Allergies: List any allergies (food, medication, environmental, etc.)_____
Identify the things that could start an asthmatic episode (check any that apply child):

___Animals ___Bee/Insect Sting ___Change in temp ___Dust mites

___Exercise ___Latex ___Molds ___Pollens

___Smoke ___Strong odors ___Respiratory Infections

___Foods*_____

___Other_____

**Must have a physician signed Medical Statement for Children with Special Dietary Needs on file for the program's nutrition program.*

Control of the Program environment:
List any environmental control measures, and/or dietary restrictions that your child needs to avoid an asthma episode (ozone warning, heat index, and food):
_____
_____

Outside activity & field trips: List the medications that must accompany your student on these activities.

Name of Medication	Dosage	When to use

YOUR student's symptoms of an asthma attack: (Check any that apply)

___Difficulty breathing ___Coughing ___Wheezing ___Grunting
___Chest feels tight ___ Nostril flaring ___Can't catch his/her breathe
___Hunches over to breathe easier ___Speaks in very short, choppy sentences
___Shortness of breath ___Skin, lips &/or fingernails look gray, blue or purple
___Other_____

_ **The usual procedures at CGYC for a student having a suspected asthma attack:**

1. Remove the student from the environment of triggering agent(s).
2. Let the student take a comfortable position.
3. Attempt to calm & reassure the student.
4. Assess for the severity of the attack.
5. If parents/legal guardians provide a peak flow meter, take a reading & compare to student's desired peak flow reading.
6. Give **emergency medications** listed below <u>if student is experiencing the following:</u>
   SYMPTOMS:_____
   _____
7. Check for decreased symptoms and/or increased peak flow reading.
8. Parent/legal guardian will be notified of any asthmatic symptoms, whether mild or severe.
9. Seek **Emergency Medical Services** if student is not improving.

EMERGENCY Asthma Medications(s)

Name of Medication	Dosage	When to use

Did you provide CGYC with <u>emergency medication</u>? ____Yes* ____No

If you provide the program with **emergency medication such as an inhaler, a medication form **must** be filled out **<u>before</u>** your child can receive any medication.*

_____ _____

Parent/Guardian Signature & Date *Program Director Signature & Date*

Updated 2/21