Asthma/Reactive Airway Disease (RAD) Individual Child Care Plan

Child's Name: _____ Date of Birth: ___/___/___
Allergies: _____

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: _____
Name Home # Work # Other

Parent/Guardian #2: _____
Name Home # Work # Other

(see emergency contact information for alternate if parents are unavailable)

Primary health provider's name: _____ **emergency phone**: _____
Asthma specialist's name (if any): _____ **emergency phone**: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER

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

colds	tree pollens	grass	aerosol sprays	mold
powder/chalk dust	weather changes	animals	flowers	exercise
strong odors	room deodorizers	smoke	house dust	excitement

foods (specify) _____
other (specify) _____

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

Outdoors	*Indoors*
field trips to see animals/farms	kerosene/wood stove heated rooms
running hard	art projects with chalk, glues, fumes
gardening, jumping in leaves	pet care
outdoors on cold or windy days	recent pesticide application in facility
playing in freshly cut grass	painting or renovation in facility
other (specify) _____	sitting on carpets

Special considerations: related to his/her asthma while at the program? (Check any that apply and describe briefly.)

- ☐ Modified physical activities _____
- ☐ Modified outdoor times or activities _____
- ☐ No animal pets in classroom _____
- ☐ Avoiding certain foods _____
- ☐ Emotional or behavior concerns _____
- ☐ Special consideration while of field trips _____
- ☐ Observation for side effects from medication (see back page).
- ☐ Need to take medication while at the program (see back page).
- ☐ Other _____

Can this child use a **flowmeter** to monitor need for medication in child care? ___ Y ___ N
Personal best reading; _____ reading to give extra dose of medicine; _____ reading to get medical help; _____

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? _____

Special physician/parents orders: _____

Medications (routine and emergency): See back page

- Over -

Reminders:

1. *Notify parents immediately if emergency medication is required.*
2. *Get emergency medical help if:*
   - the child does not improve 15 minutes after treatment and family cannot be reached
   - after receiving a treatment for wheezing, the child:

is working hard to breathe or grunting	cries more softly and briefly
is breathing fast at rest (>50/min)	has gray or blue lips or fingernails
won't play	has trouble walking or talking
is hunched over to breathe	has nostrils open wider than usual
is extremely agitated or sleepy	
has sucking in of skin (chest or neck) with breathing	

3. *The child's doctor and the child care facility should keep a current copy of this form in the child's file.*

Medications for routine and emergency treatment of asthma for _____
(child's name)

Name of Medication				
When to use give specific symptoms (i.e.: coughing, cold symptoms, wheezing, respiratory rate of ___ per minute)				
How to use (e.g. by mouth, by inhaler, with or without spacing 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				

Physicians Signature: _____ Date: ___/___/___

Parent/Guardian Signature: _____ Date: ___/___/___

TRAINED CHILD CARE PROVIDERS:

1. _____ Room: _____

2. _____ Room: _____

Plan of care reviewed by:

Director: _____ Date: ___/___/___

Teacher: _____ Date: ___/___/___

Child Care Health Consultant: _____ Date: ___/___/___

Projected date of plan re-evaluation (every six months or sooner if needed): Date: ___/___/___