Village Early Childhood Center
P (201) 767-9909
F (201) 767-9919

Daycare Asthma Action Plan

*Any child with diagnosed asthma must have the following action plan on file. **You must provide the Center with any medication or accessory (spacer, nebulizer) marked below for use at school. All medications must be in their original packaging, labeled with your child's name and registered pharmacy information as prescribed by law. These medications must be kept at the Center. When possible, medications sent to school should be administered at least once at home to test for an allergic reaction.*

Child's Name: _____ **Child's DOB**: _____

TO BE COMPLETED BY CHILD'S HEALTHCARE PROVIDER:

Severity classification: ☐ Intermittent ☐ mild persistent ☐ moderate persistent ☐ Severe persistent

Asthma triggers (list):

GREEN ZONE ***Take these actions when the following symptoms are present:***
Breathing is good, no coughing or wheezing, can work/play, sleeping through the night

Medication Name: _____
Dose: _____
Frequency: _____
Route: _____

Medication Type: ☐ Control ☐ Quick-Relief
Additional Equipment:
☐ via spacer ☐ via nebulizer
Taken at *(mark all that apply):*
☐ Home ☐ School

Medication Name: _____
Dose: _____
Frequency: _____
Route: _____

Medication Type: ☐ Control ☐ Quick-Relief
Additional Equipment:
☐ via spacer ☐ via nebulizer
Taken at *(mark all that apply):*
☐ Home ☐ School

Other Actions:

YELLOW ZONE ***Take these actions when one or more of the following symptoms are present:***
Coughing, wheezing, tight chest, coughing through night

Medication Name: _____
Dose: _____
Frequency: _____
Route: _____

Additional Equipment: ☐ via spacer ☐ via nebulizer
Taken at *(mark all that apply):* ☐ Home ☐ School

Other Actions:

RED ZONE	***Take these actions when one or more of the following symptoms are present:*** *Breathing is hard and fast, can't talk well, medicine is not helping*

Medication Name: _____

Dose: _____

Frequency: _____

Route: _____

Additional Equipment: ☐ via spacer ☐ via nebulizer

Taken at *(mark all that apply):* ☐ Home ☐ School

Call Parents/Guardians if the following symptoms are present:

Call 911 (emergency medical services) if the following symptoms are present, and contact parents/guardians:

Take these measures while waiting for Parents/Guardians or medical help to arrive:

Healthcare Provider completing this form:

_____ *(Provider Name)*

_____ *(Provider Phone)*

_____ *(Provider Signature)*

_____ *(Signature Date)*

TO BE COMPLETED BY CHILD'S PARENT/GUARDIAN:

Parent/Guardian Name(s):	Phone:

Does your child have a known allergy/reaction to the medication listed on this form? ☐ **Yes** ☐ **No**

Has the medication on this form ever been administered to your child? ☐ **Yes** ☐ **No**

Comment:

I acknowledge that I am required to document in the Tadpoles app any doses of medication my child receives before their arrival at the Program each morning.

I authorize Village Early Childhood Center, including it's Administrators, Staff, Volunteers, or other agents to administer the above medications to my child or provide or arrange medical care for my child in accordance with this Asthma Action Plan. I release and discharge Village Early Childhood Center, it's Administrators, Staff, Volunteers, or other agents from all claims and liability for any loss or injury that may occur in the future as a result of care provided under this authorization and release.

I hereby give consent for the provider listed above to communicate with Village Early Childhood Center to discuss any of the information on this form.

_____ *(Parent/Guardian Name)*

_____ *(Parent/Guardian Signature)*

_____ *(Date)*

This consent expires one year after the date it was signed, unless otherwise noted.