



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 CYC/CCP 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 if student is experiencing the following:
 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 CYC/CCP with emergency medication? Yes* No

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

Parent/Guardian Signature & Date

Program Director Signature & Date