Asthma Action Plan

Child's Name:_____ DOB:_____ Classroom:_____

List things that may make child's asthma worse:_____

GO – You're Doing Well! ➔ Use these daily controller medicines:

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can go to school and play

Medication	Dose	How Often	
			❒ This medication is taken at home
			❒ This medication is taken at home
			❒ This medication is taken at home

CAUTION – Slow Down! ➔ Continue with daily controller medicine ***and add***:

You have *any* of these:
- First signs of a cold
- Cough
- Mild wheeze
- Tight chest
- Cough, wheeze or trouble breathing at night

Medication	Dose	How Often*	
			*** DO NOT exceed _____ doses in _____ hours.**
			*** DO NOT exceed _____ doses in _____ hours.**
			*** DO NOT exceed _____ doses in _____ hours.**

Notes (any other info that will help us in determining when to administer medication):

For Inhaled Medications:

☐ I have instructed (child's name)_____ in the proper way to use his/her medications.
It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.

☐ It is my opinion that (child's name)_____ should not carry his/her inhaled medication by him/herself.

DANGER – Get Help! ➔ Take these medicines and **call 911** now

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Can't talk well

Medication	Dose	How Often	

I, (parent's name)_____, attest that the above information is true and accurate. I am responsible for providing the Girls Club with up to date information and medications necessary for my child's health and safety.

Parent Signature:_____

Date:_____

I, (physician's name)_____, authorize the child's parent to train the staff at the Girls Club of Greenfield on how to administer these medications.

Physician Signature:_____

Date:_____

Individual Health Care Plan

Plan must be renewed annually or when child's condition changes

Plan was created by: Physician or Licensed Practitioner **Plan maintained by:** Leanne Du Pree

Name of child: Date:
Any change to the child's Health Care Plan? **YES** (indicate changes below) **NO** (updated physician/parental signatures required)
Name of chronic health care condition: □ Asthma □ Allergy Please specify:_____ □ Seizure Disorder □ Diabetes □ Other (Be specific)_____
Potential side effects of treatment:
Potential consequences if treatment is not administered:
Name of educators that received training addressing the medical condition *(filled out by agency if required)*:

Name of Physician (please print):_____

Physician Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

For Older Children ONLY (9+ years of age)

With written parental consent and authorization of a licensed health care practitioner, this Individual Health Care Plan permits older school age children to carry their own inhaler and/or epinephrine auto-injector and use them as needed without the direct supervision of an educator.

The educator is aware of the contents and requirements of the child's Individual Health Care Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medicationfor use as needed.

Age of child:_____ Date of birth:_____ Back-up medication received? YES NO

Parent/Guardian Signature:_____ Date:_____

Administrator's Signature:_____ Date:_____