ASTHMA
INDIVIDUAL CARE PLAN

Child's Name		Place picture of child here
Date of Birth		
***Parent/Guardian** (name and phone number)		
***Parent/Guardian** (name and phone number)		
Health Care Provider (name and phone number)		

**See emergency contact information on file if parents are unavailable*

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

Colds	Mold	Exercise	Tree pollens
Dust Mites	Strong odors	Grass	Flowers
Excitement	Weather Changes	Animals	Smoke
Room Deodorizers	Other (specify)		
Foods (specify)			

Activities child has needed special attention with in the past

(circle all that apply)

Field trip to see animals	Kerosene/wood stove heated rooms
Running hard	Art projects with chalk, glues, fumes
Gardening	Sittings on carpets
Jumping in leaves	Pet care
Outdoors on cold or windy days	Recent pesticides application in facility
Playing in freshly cut grass	Painting or renovation in facility
Other (specify)	Scents from cleaning products

- Can this child use a **flowmeter** to monitor need for medication in childcare? YES NO
- How often has this child needed **urgent care** from a doctor for an asthma flare/attack in the past 12 months? _____

Typical signs and symptoms of child's asthma flares/attacks

(circle all that apply)

Fatigue	Face red, pale or swollen	Grunting
Breathing faster	Wheezing	Sucking in chest/neck
Restlessness, agitation	Dark circles under eyes	Persistent coughing
Complaints of chest pain/tightness	Gray or blue lips or fingernails	Flaring nostrils, mouth open (panting)
Difficulty playing, eating, talking	Wheezing (whistle breathing)	

Asthma Action Plan for _____ (name of child)

1. Good Control	**Daily Medicines- Use Every Day**		
Child feels good: • Breathing is good • No cough or wheeze • Can work/play • Sleeps all night **OR** • Peak flow in this area most of the time: _____	**Medicine**	**How much to take**	**When**
	20 minutes before exercise use this medicine:		

2. Be Careful	**Take Daily Medicines and Add these Medicines**		
Child has any of these: • Cough • Wheeze • Tight chest • Wakes up at night **OR** • Peak flow in this area most of the time: _____	**Medicine**	**How much to take**	**When**
	Call doctor if quick relief medicine is used more than _____ per week.		

3. Danger-Call Health Care Provider Now!	**Take Daily Medicines**		
Child has any of these: • Medicine not helping • Breathing hard and fast • Nose opens wide • Can't walk or talk well • Ribs show **OR** • Peak flow in is below _____	**Medicine**	**How much to take**	**When**
	Call 911 **if lips are bluish, getting worse fast, struggling to breathe, can't talk/cry because of hard breathing or has passed out**		

Training Needs: (Parent/Guardian or child's health care provider will be responsible for staff trainings related to specific child care procedures)

_____ _____
Health Care Provider Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____ _____ _____
Director Signature Date Supervisor Signature Date

_____ _____ _____ _____
Teacher Signature Date Teacher Signature Date

Complete both sides of this form