



<b>Asthma Care Plan</b>		
Childs Name: _____	Grade: _____	Div: _____
Facility Name: _____		Facility Address: _____

Child's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

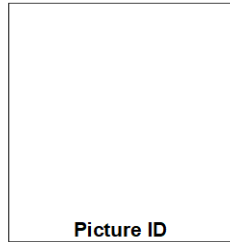
Parent/Guardian: \_\_\_\_\_

Phone (home/cell): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Office Phone: \_\_\_\_\_



• **GIVE** \_\_\_\_\_  
(name of medication)

• **Follow Instructions:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CHILD'S ASTHMA TRIGGERS ARE:**

change in temperature     colds, infection     dust, mites     emotion (e.g. upset)     mould     physical activity     pollen

animals (list): \_\_\_\_\_

foods (list): \_\_\_\_\_

strong smells (list): \_\_\_\_\_

Other: \_\_\_\_\_

**CHILD'S ASTHMA SYMPTOMS ARE USUALLY:**

appears anxious     short of breath

coughing     wheezing

difficulty talking     in-drawing/tracheal tug

fast/shallow breathing     other (list below): \_\_\_\_\_

pale   

hunched over   

**CHILD'S EMERGENCY TREATMENT:**

Medication is stored: \_\_\_\_\_

Medication expiry date: \_\_\_\_\_

Names of staff oriented to plan: \_\_\_\_\_

Emergency plan review date (to do yearly): \_\_\_\_\_

Field Trip Plans: \_\_\_\_\_

• **If unsure, child is worse, or not getting better CALL 911**

• **CALL PARENTS**

*It is the parent's responsibility to notify the facility of any change in the child's condition.*

Sign below if you agree with above Information & Plan:

Health Care Provider (ie. Dr/Specialist/NP) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Childcare Supervisor/School Personnel \_\_\_\_\_ Date \_\_\_\_\_

Asthma Care Plan is provided as a resource from Vancouver Coastal Health – April 2013

