Asthma Care Plan

Childs Name: ______________________________ **Grade:**________ **Div:** _______

Facility Name: ______________________ **Facility Address:**______________________________

Child's Full Name:

Date of Birth:

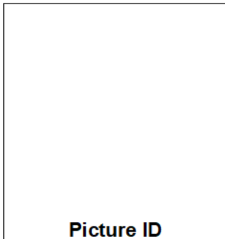
Parent/Guardian:

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

Emergency Contact:

Phone (home): Phone (work):

Health Care Provider: Office Phone:



Picture ID

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:

- **GIVE** ______________________
  (name of medication)
- **Follow Instructions:**

____

____

____

____

- **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