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 <u>all</u> of these:	Medication	Dose	How Often	
 Breathing is good No cough or wheeze Sleep through the night Can go to school and play 				This medication is taken at home
				This medication is taken at home
				This medication is taken at home

CA	CAUTION – Slow Down! → Continue with daily controller medicine <i>and add</i> :					
You have <u>any</u> of these:		Medication	Dose	How Often*		
•	First signs of a cold Cough				* DO NOT exceed doses in hours.	
•	Mild wheeze Tight chest				* DO NOT exceed doses in hours.	
•	Cough, wheeze or trouble				* DO NOT exceed doses in hours.	
breathing at night		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!	Get Help! → Take these medicines and call 911 now			
Your asthma is getting worse fast:	Medication	Dose	How Often	
 Medicine is not helping Breathing is hard and fast 				
 Dreating is hard and last Nose opens wide Ribs show 				
Can't talk well				

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.	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.
Derent Signatura:	Physician Signature:
Parent Signature:	Date:
Date:	

Individual Health Care Plan

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

Jame of Physician (please print):	Plan was created by: Physician	or Licensed Practitioner Plan	n maintained by: Nichole Clayton
YES (indicate changes below) NO (updated physician/parental signatures required) Name of chronic health care condition:	Name of child:		Date:
Name of chronic health care condition: Asthma Altergy Please specify:			
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): are of educators that received training addressing the medical condition (filled out by agency if required): And the specific output of the specific output of the medical condition (filled out by agency if required): 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 of the 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 permits needed to carry his or her own medication, the licensee must maintain on-site a back-up supply of the medicator or ear needed. Age of child: Parent/Guardian Signature: Date: D	YES (indicate changes below)	NO (updated physician/parental signatu	ures required)
Allergy Please specify:			
□ Seizure Disorder □ Diabetes Other (Be specific)			
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		Date of birth:	Back-up medication received? YES NO
Administrator's Signature: Date:	Parent/Guardian Signature:		Date:
	Administrator's Signature		Date: