Asthma/Reactive Airway Disease (RAD) Individual Care Plan

Child's Name	Date of Birth
Allergic to	

Emergency Phone Numbers

Parent/Guardian #1: ______________________________

Name | Home # | Work# | Other#

Parent/Guardian #2: ______________________________

Name | Home # | Work# | Other#

(*See emergency contact information for alternate if parents are unavailable*)

Primary health care provider's name: ______________________ Phone: __________

Specialist's name (if any): ______________________ Phone: __________

To Be Completed By Health Care Provider

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

colds	tree pollens	grass	aerosol sprays	mold	animals
powder/chalk dust	weather changes	smoke	flowers	exercise	excitement
strong odors	room deodorizers	house dust			

foods (specify)______________________________

other (specify)______________________________

Activities for which this child has needed special attention in the past: (*circle all that apply*)

Outdoors	Indoors
field trips to see animals/farms	kerosene/wood stove heated rooms
running hard	art projects with chalk, glue, fumes
gardening, jumping in leaves	pet care
outdoors on cold or windy days	recent pesticide application in facility
playing in freshly cut grass	painting or renovation in facility
other (specify) ______________	sitting on carpets

Special considerations related to his/her asthma while at the program (*Check any that apply and describe briefly.*)

- ☐ Modified physical activities ______________________________
- ☐ Modified outdoor times or activities______________________________
- ☐ No animal pets in classroom______________________________
- ☐ Avoiding certain foods______________________________
- ☐ Emotional or behavior concerns ______________________________
- ☐ Special considerations while on field trips______________________________
- ☐ Observation for side effects from medication (see back page) ______________________________
- ☐ Need to take medication while at the program (see back page)______________________________
- ☐ Other ______________________________

Can this child use a **flowmeter** to monitor need for medication in child care? ☐ Yes ☐ No

personal best reading________ reading to give extra dose of medicine ________

reading to get medical help _______

How often has this child needed urgent care from a doctor for an attack of asthma

in the past 12 months? _______ in the past 3 months? _______

Special physician/parent orders:______________________________

____

____

Reminders

1. Notify parents immediately if emergency medication is required.
2. Get emergency medical help if:
   - The child does not improve 15 minutes after treatment and family cannot be reached
   - After receiving treatment for wheezing, the child:

     is working hard to breathe or grunting
     is breathing fast at rest (>50/min)
     is extremely agitated or sleepy
     is hunched over to breathe
     cries more softly and briefly
     has gray or blue lips or fingernails
     has sucking in of skin with breathing
     has nostrils open wider than usual
     won't play
     has trouble talking
     has trouble walking
3. The child's doctor and PB & J Day School should keep a current copy of this form in the child's file.

Medications for routine and emergency treatment of asthma for ____________________ (*child's name*)				
Name of Medication				
When to use: Give specific symptoms (i.e. coughing, cold symptoms, wheezing, respiratory rate ____ per minute)				
How to use: (e.g. by mouth, by inhaler, with or without spacing device, in nebulizer, with or without dilution, diluting fluid, etc)				
Amount (dose) of medication				
How soon treatment should start to work				
Expected benefit for the child				
Possible side effects, if any				

Physician's Signature: ______________________________ Date ____________

Parent/Guardian Signature: ______________________________ Date ____________

Trained Child Care Providers:

1. ______________________________ Room: ____________
2. ______________________________ Room: ____________

Plan of care written in collaboration with:

Director ______________________________ Date: ____________

Teacher ______________________________ Date: ____________

Projected date of plan re-evaluation: ____________________