School Year
20__ - 20__

Tri-County Community Council, Inc.
Head Start

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Page to be completed with input by Parent/Guardian
Please Print

ASTHMA ACTION PLAN

Child Information Center:_____

Name of Child:_____

Date of Birth:_____ Child's Age:_____ Classroom Teacher:_____

Emergency Information

Parent(s') or Guardian(s') Names:_____

Mother's Telephone (H):_____ Father's Telephone (H):_____

Pager:_____ Pager:_____

Telephone (W):_____ Telephone (W):_____

Primary Care Physician:_____ Telephone:_____

In the event a parent/guardian cannot be reached:

1._____ Relation:_____ Telephone:_____

2._____ Relation:_____ Telephone:_____

_Preferred Local Emergency Department:_____

Triggers that may bring on an asthma episode:

- ☐ Cigarette Smoke
- ☐ Exercise
- ☐ Exposure to cold air
- ☐ Emotional stress
- ☐ Odors
- ☐ Respirator infection
- ☐ Allergic reactions, such as food or insects (describe) _____
- ☐ Paint fumes
- ☐ Other (carpets, chalk dust, etc.): _____

ALL CURRENT MEDICATIONS

Name of Medication	Dosage and Strength	Purpose	Day Schedule	Time of Day

List an environmental e measures, pre-medications or dietary restrictions needed to prevent an asthma episode:

_____

Signs and symptoms: (Please check the symptoms that occur in your child.)

- ☐ 1. Cough
- ☐ 2. Bluish color skin/nails
- ☐ 3. Tired
- ☐ 4. Wheezing
- ☐ 5. Fear
- ☐ 6. Shortness of breath
- ☐ 7. Unable to speak without taking a breath
- ☐ 8. Other:

Does child use peak flow meter? Yes____ No____

If yes, Daily_____ Occasionally_____ Personal best peak flow_____

My child has the following other chronic illnesses/disabilities:

_____

Allergies:_____

_____

Child's Limitations or Special Considerations:

_____

I understand that it is my responsibility to keep this information current. Please notify the Center Coordinator and provide an updated/current form on at least an annual basis.

Parent/Guardian's Signature:_____ **Date:**_____

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ASTHMA ACTION PLAN: Steps for an Acute Asthma Episode

Child's Name:_____
Risk:

- ❑ Mild
- ❑ Moderate
- ❑ Severe

1. Seek emergency medical help if the child:
   - Shows no improvement 15 minutes after initial treatment with medication and a relative cannot be reached.
   - Has peak flow reading of _____.
   - Struggled for breathe, hunches over, or sucks in chest and neck muscles in an attempt to breathe.
   - The child has difficulty in walking or talking, i.e, can not speak in complete sentences.
   - Blue or gray discoloration of the lips or fingernails.

These above signs indicate the need for immediate emergency medical care. The steps that should be taken are:

- If in doubt, activate the emergency medical system in your area: Call 911.
- Call First Response person in your school or appropriate person in your program.
- Call child's physician.
- Call parent/guardian. It is the parent's responsibility to determine follow-up to symptoms.

2. Give medication as listed below.
3. Child may return to classroom or program if:

   _____

4. Parent wishes to be contacted if:

   _____

Preferred Local Emergency Department:_____
It is the parent's responsibility to determine follow-up care for symptoms.

Emergency Asthma Medications:

Name of Medication	Dosage and Strength	When to Use

Special Instructions:
1._____
2._____
3._____

This child also has the following chronic illnesses/disabilities:_____

Health Services Coordinator:_____ Phone:_____ Date:_____

INFORMATION REVIEWED AND CORRECTED (REVIEW DATES/INITIALS OF REVIEWING INFORMATION)

Date:									
Parent:									
Health Services Coordinator:									