Grace Children's Learning Center
9750 Wellington Rd Manassas, VA 20110
703-393-2345

Care Plan for Asthmatic Children

Child's Name:____________________________________ Date of Birth: ___________

This plan is to help you know the child's triggers, early warning signs and symptoms of an asthma episode. It includes what you should do if the child has an asthma episode while in care. If the child takes medication, follow the instructions on the child's Written Medication Consent Form.

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

colds excitement mold weather changes exercise animals

tree pollens smoke dust grass

strong odors ____

other: ____

flowers ____

foods:____

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

Outdoors Indoors outdoors on cold or windy days kerosene/wood stove

animals jumping in leaves painting or renovations heated rooms

running hard art projects gardening pet care

playing in freshly cut grass sitting on carpets recent lawn treatment

other: ____

Early Warning Signs for this child's asthma (circle all that apply)

behavior changes, such as nervousness headache rapid breathing fatigue

wheezing, coughing changes in peak flow meter readings

stuffy or runny nose watery eyes, itchy throat or chin

other: ______________________________ ________________________________

__________________________________ _______________________________

Typical signs and symptoms of this child's asthma episodes (circle all that apply)

fatigue | agitation | red, pale or swollen face | flaring nostrils

grunting | mouth open (panting) | breathing faster | persistent coughing

wheezing | restlessness | complaints of chest pain/tightness

dark circles under eyes | gray or blue lips or fingernails | difficulty playing, eating, drinking, talking

sucking in chest/neck

Other: _________________________

Peak Flow Meter

Does this child use a peak flow meter to monitor the need for medication in care? ___Yes ___No

• Personal best reading _____________

• Reading to give extra dose of medicine _____________

(See the child's Written Medication Consent Form for instructions.)

• Reading to get medical help _____________

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

• in the past 3 months? _________ • in the past 12 months? _________

Staff

Identify the staff who will provide care to this child: ____

Name Credentials or Professional License Information ____

Describe any additional training, procedures or competencies the staff listed will need to care for this child. Also describe how this additional training and competency will be achieved, including who will provide this training. This includes training for using a peak flow meter, if the child uses one to help manage asthma.

Plan of Action if child is having an asthma episode

1. Remove child from any known triggers.

2. Follow any health care provider instructions for administration of asthma medication.

3. Notify parents immediately if medication is administered.

4. Get emergency medical help if:

* the child does not improve 15 minutes after treatment and family cannot be reached

OR

After receiving a treatment, the child

* is grunting or working hard to breathe

* won’t play

* has gray or blue lips or fingernails

* cries more softly and briefly

* is hunched over to breathe

* is extremely agitated or sleepy

* is breathing fast at rest (>50/min)

* has trouble walking or talking

* has nostrils open wider than usual

* has sucking in of skin (chest or neck) with breathing

* passes out or stops breathing

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child’s parent and the child’s health care provider. *I understand that it is my responsibility to see that the staff identified to provide all treatments and administer medication to the child listed in this health care plan have a valid MAT certificate, CPR and first aid certifications, or have a license that exempts them from training; and have received any additional training needed, and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility Name: Facility Telephone

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____ ___________________________
Physician Signature Date

____ ___________________________
Signature of Parent or Guardian Date

____ ___________________________
Authorized child care provider’s name (please print) Date

____
Authorized child care provider’s signature