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Educating Children, Inspiring Our Future

Asthma Care Plan—Parent/Guardian

Child's Name: _____

Family Information	**Health Care Provider Information**
Parent/Guardian's Name:	Name of Health Care Provider:
Home Phone # Work #	Phone #:
Emergency Contact:	**Emergency Contact:**
In Emergency Call:	In Emergency Call:
Phone #	Phone #

My child's early warning signs of asthma attack:

_____

My child's emergency warning signs of asthma attack:

_____

My child's asthma triggers (examples: dogs, dust, colds):

_____

My Child's Medications *(Authorization of Medication form to be completed)*			
Name of Medication	When to take it	Device Used	Medication expiration

By signing this form, you consent for us to exchange information with your child's health care provider as needed. You certify that you have personally instructed the teaching staff on how to administer inhaled medication to your above named child (in compliance with CCL Health & Safety Code Section 1596.798).

Parent/Guardian Signature:_____Date:_____

Kidango Staff
Signature_____Date:_____

This form and the Authorization for Medication Form must be completed, on file, and reviewed with Center Director or designated staff before child can be accepted for child care services
Please make a copy for the child's parent/guardian

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Asthma Care Plan—Physician's Instructions

To be completed by the child's Physician/Health Care Provider, in accordance with Community Care Licensing Health & Safety Code.

Child's Name: _____ DOB:_____

Parent/Guardian:_____

Physician/Healthcare Provider's Name:	Physician/Healthcare Provider's Phone #
Form completed by:	Date:

Prescribed Controller Medicines (used everyday)	**How Much to Take (dosage)**	**How Often**	**Other Instructions (spacers, masks, nebulizers)**
		_____ times per day	
		_____ times per day	
Quick-Relief Medicines:	**How Much to Take (dosage)**	**Only as needed**	**Other Instructions**

Name of Medication:	Potential Side Effects:	Proper Storage Instructions:

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Asthma Care Plan—Physician's Instructions

To be completed by the child's Physician/Health Care Provider, in accordance with Community Care Licensing Health & Safety Code.

Child's Name: _____ DOB:_____

Parent/Guardian:_____

Specific Indications/Symptoms for administering inhaled medication:

Green Zone:	**Yellow Zone:**	**Red Zone:**	Health Care Provider's Additional Notes/Instructions:
Child is well and has no asthma symptoms	Child is NOT well and has symptoms that may include: • Coughing • Wheezing • Runny Nose • Breathing Harder or faster	Child feels awful! • Coughing/wheezing continues, worsens • Breathing difficulty—child has trouble walking/talking	
Staff Plan of Action	Staff Plan of Action:	Staff Plan of Action	
Monitor and Prevent: administer controller meds as instructed	Move child to a quiet setting; administer quick relief medication as instructed	**Call 911 and notify parent!**	

Parent/Guardian Signature (consent to implement this plan):_____
Date:_____

Kidango Staff Name:_____
Kidango Staff Signature:_____ Date:_____

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Please make a copy for the child's parent/guardian