ASTHMA ACTION CARE PLAN

HS1 1.5b

Child's Name: ____ **Date of Birth** _____/_____/_____

Parent /Guardian: ____

Emergency Phone Numbers: Parent/Guardian: ____________________________If no answer call: ______________________ *(See emergency contact information for alternate contacts if parents are unavailable)*

Primary Health Care Provider: ___________________________ **Phone #:**______________________
Asthma Specialist: *(if any)* ______________________________ **Phone #:** ______________________

To be completed by the Healthcare Provider/Physician

1. **Asthma Severity** (Circle One): Mild Intermediate Mild Persistent Moderate Persistent Severe Persistent
2. Should this child use a flow meter to monitor need for medication in Head Start? ___NO ___YES
3. 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 __________________

GREEN ZONE

DOING WELL

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

PREVENT asthma symptoms every day:

☐ Administer controller medicines every day
☐ Before exercise, administer___ puffs of ______________________ or one nebulizer treatment of ______________________
☐ Avoid things that make asthma triggers

Controller Medicines (to be given at home)	Dosage/Route (how much and how to take)	Time/How often	Other instructions
		____times per day	
		____times per day	

YELLOW ZONE

Asthma is getting worse

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities

Caution Continue taking everyday controller medicines, AND

☐ Administer ___ puffs of ______________________________or one nebulizer treatment of ___________________________
☐ If after the administration of the first inhaler or nebulizer treatment, the child does not improve within _________ minutes, administer ___ puffs of ____________________________or one nebulizer treatment of ______________________
☐ Contact the parent if child does not improve within ______minutes

Quick Relief/Emergency Medications (to be given at school if needed)	Dosage/Route (how much and how to take) *MUST match prescription label	Time/How often Take only as needed in accordance to yellow and red zone indicators *MUST match prescription label	Other instructions
			Carry on the bus __ Yes ___No
			Carry on the bus __ Yes ___No

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Childs Name: ____ DOB: _______________

RED ZONE MEDICAL ALERT

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- symptoms are the same or get worse after _____ minutes in the yellow zone

Medical Alert! Get HELP!

- ☐ Administer quick relief medicine ___ puffs of ___________________ or one nebulizer treatment of ___________________and
- ☐ GET HELP immediately
- ☐ Call 911 if the child has trouble walking or talking due to shortness of breath, if the lips and fingernails are gray or blue, if the skin around the neck and ribs is sucked in, or if the child doesn't respond normally
- ☐ Call Parent

Known Triggers for this child's Asthma *(circle all that apply)*:

Colds	Tree Pollens	Grass	Weather Changes
Mold	House Dust	Excitement	Animals
Exercise	Strong Odors	Flowers	Smoke

Foods (specify): ____

Other (specify): ____

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

Outdoors	*Indoors*
Field trip to see animals	Kerosene/wood stove heated rooms
Running hard	Art projects with chalk, glues, fumes
Gardening	Sitting on carpets
Jumping in leaves	Pet care
Outdoors on cold or windy days	Recent pesticides application in facility
Playing in freshly cut grass	Painting or renovation in facility

Other (specify): ____

Healthcare Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state and federal laws and regulations.

Health Care Provider Signature: ______________________________________

Date: _______________

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Childs Name: ___________________________________ **DOB:** ______________

To be completed by Parent or Guardian

I have developed this health plan in partnership with my child's healthcare provider and Head Start staff. I will communicate any changes in my child's identified health condition or treatment to Head Start staff as changes occur.

Effective ___________________**Expires** _____________________

This plan will be reviewed and updated annually.

As the parent/legal guardian of ____(Child's Name), I ___________________________________(Parent/Guardian Name) give my Permission for OVEC Staff to administer the Emergency Action Plan including the administration of Medication as stated in this plan and post information under the classroom Health Alert. I further release OVEC and its employees from any claims or liability connected with its reliance on this permission

Parent/Guardian (print name) _______________________________

Parent/Guardian Signature _______________________________ Date: _____________

To be completed by Staff after being trained

By signature, staff acknowledges education by parent or guardian on condition(s) and requirement of emergency care and/or medication if needed.

(All staff in center must be trained):

Staff Signature _______________________________ Date: ___________

Staff Signature _______________________________ Date: ___________

Staff Signature _______________________________ Date: ___________

Staff Signature _______________________________ Date: ___________

Staff Signature _______________________________Date: ___________