

# Asthma Health Care Plan

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**The following information should be completed by the child's health care provider.**

**Severity:**  Mild  Mild Persistent  Moderate Persistent  Severe Persistent

Check All Triggers		
<input type="checkbox"/> Cleaning Products	<input type="checkbox"/> Exercise	<input type="checkbox"/> Pet Dander
<input type="checkbox"/> Colds/Flu	<input type="checkbox"/> Food	<input type="checkbox"/> Smoke
<input type="checkbox"/> Cut Flowers, Grass, Pollen	<input type="checkbox"/> Odors/Fragrances	<input type="checkbox"/> Sudden Temperature Change
<input type="checkbox"/> Dust Mites	<input type="checkbox"/> Ozone Alert	
<input type="checkbox"/> Other: _____		

**Suggested classroom strategies to support this child's needs:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Specific Medical Information:

Medication to be administered:\*  Yes  No If yes, medication to be administered and potential side effects: \_\_\_\_\_

\_\_\_\_\_

*\*For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the Medication Authorization form.*

Potential consequences to child if treatment is not administered: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Staff Training Needs: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Additional Emergency Procedures/Instructions (including when 911 should be called):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### GO (Green Zone)

<b>If the child:</b> <ul style="list-style-type: none"> <li>Is breathing regularly</li> <li>Has no coughing or wheezing</li> <li>Can engage in active play</li> </ul>	<b>What to do:</b> <ul style="list-style-type: none"> <li>Allow current activity</li> </ul>	<b>Medication:</b> <ul style="list-style-type: none"> <li>"As needed medication" not needed</li> <li>Regular medication to be given as ordered</li> </ul>
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### CAUTION (Yellow Zone)

<b>If the child has:</b> <ul style="list-style-type: none"> <li>Early signs of a cold (runny nose,</li> </ul>	<b>What to do:</b> <ul style="list-style-type: none"> <li>Cease current activity</li> </ul>	<b>Medication</b> <ul style="list-style-type: none"> <li>Administer the "As needed"</li> </ul>
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<ul style="list-style-type: none"> <li>sneezing)</li> <li>Exposure to a known trigger</li> <li>Coughing</li> <li>Mild wheezing</li> <li>Chest tightness</li> </ul>	<ul style="list-style-type: none"> <li>If the child is outdoors bring inside</li> <li>Observe breathing before and after the treatment (15 minutes)</li> </ul>	medication” per the <u>Medication Authorization Form</u> and follow directions for use <ul style="list-style-type: none"> <li>Monitor breathing status if no improvement follow the steps for the DANGER (Red Zone)</li> </ul>
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**DANGER (Red Zone)**

<p><b>If the child’s asthma worsens and any of the following apply:</b></p> <ul style="list-style-type: none"> <li>The medications are not helping within 15-20 minutes of administration.</li> <li>Breathing is becoming hard and fast</li> <li>Nose (nostrils) open wide</li> <li>Ribs are showing</li> <li>Lips, fingernails or mouth area are blue or blue gray in color</li> <li>Trouble walking or talking</li> </ul>	<p><b>What to do:</b></p> <ul style="list-style-type: none"> <li>Call 911</li> <li>Stay with the child—Stay calm</li> <li>Ancillary staff notify the parent/guardian</li> <li>Accompany the child to ER</li> <li>Complete an Occurrence Report within 24 hours</li> </ul>	<p><b>Medication:</b></p> <ul style="list-style-type: none"> <li>Medication available has already been given with no relief</li> <li>Notify EMS staff regarding the type of medication and the time it was given.</li> </ul>
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**Staff Training**

Staff may be trained by: \_\_\_\_\_

The following staff have been trained on the child’s medical condition:

_____	_____
_____	_____
_____	_____

**Parent/Guardian Acknowledgement Statement**

To ensure the safety of your child Bright Horizons cannot delete a health care diagnosis which has previously been documented unless we have a signed note from the child’s physician stating that the condition no longer exists; nor can we add an item(s) or change a medication without a signed note from the child’s physician.

I understand that Bright Horizons requires the most up to date information regarding my child’s health. I also understand that for the safety of my child, my child’s photograph and health information will be posted in the classrooms and kitchen.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director/Principal Signature

\_\_\_\_\_  
Date

***This plan must be updated annually or whenever there is any change in treatment or the child’s condition changes.***