

Example of a Care Plan for a Child with Asthma



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 | foods: _____ |
| strong odors | _____ |
| grass | other: _____ |
| flowers | _____ |

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

- | | |
|--------------------------------|--------------------------------|
| <i>Outdoors</i> | <i>Indoors</i> |
| outdoors on cold or windy days | kerosene/wood stove |
| jumping in leaves | heated rooms |
| animals | painting or renovations |
| running hard | art projects with chalk, glues |
| gardening | pet care |
| playing in freshly cut grass | sitting on carpets |
| recent lawn treatment | other: _____ |
| 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 | complaints of chest pain/tightness |
| restlessness | gray or blue lips or fingernails |
| dark circles under eyes | 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;
 - ◇ is breathing fast at rest (>50/min)
 - ◇ has gray or blue lips or fingernails;
 - ◇ has trouble walking or talking;
 - ◇ cries more softly and briefly;
 - ◇ has nostrils open wider than usual;
 - ◇ is hunched over to breathe;
 - ◇ has sucking in of skin (chest or neck) with breathing;
 - ◇ is extremely agitated or sleepy;
 - ◇ passes out or stops breathing.

Signature of Authorized Program Representative:

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 ID number:	Facility Telephone Number:
Authorized child care provider's name (please print):		Date:
Authorized child care provider's signature:		

Signature of Parent or Guardian

	Date:
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