



National Health and Safety Performance Standards

Special Care Plan for a Child with Asthma or Allergy Hypersensitivity

Child's Name: _____ Date of Birth: _____

Primary health provider's name: _____ Emergency Phone: _____

Asthma specialist's name (if any): _____ Emergency Phone: _____

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

- | | | | |
|---|---------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Colds | <input type="checkbox"/> Mold | <input type="checkbox"/> Exercise | <input type="checkbox"/> Tree Pollens |
| <input type="checkbox"/> House Dust | <input type="checkbox"/> Strong Odors | <input type="checkbox"/> Grass | <input type="checkbox"/> Flowers |
| <input type="checkbox"/> Weather Changes | <input type="checkbox"/> Excitement | <input type="checkbox"/> Animals | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Room Deodorizers | | | |
| <input type="checkbox"/> Foods (Specify): _____ | | | |
| <input type="checkbox"/> Other (Specify): _____ | | | |

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

Outdoors

- Field Trip To See Animals
- Running Hard
- Gardening
- Jumping In Leaves
- Outdoors On Cold Or Windy Days
- Playing In Freshly Cut Grass
- Other (Specify): _____

Indoors

- Kerosene/Wood Stove Heated Rooms
- Art Projects With Chalk, Glues, Fumes
- Sitting On Carpets
- Pet Care
- Recent Pesticides Application In Facility
- Painting Or Renovation In Facility

Can the child use a **flowmeter** to monitor the need for medication in childcare? NO YES

Personal best reading: _____ Reading to give extra dose of medicine: _____

Reading to get medical help: _____

How often has this child needed urgent care from a doctor for an attack of asthma in the past twelve months? _____ In the past three months? _____

Typical signs and symptoms of the child's asthma episodes (check all that apply):

- | | | |
|---|---|--|
| <input type="checkbox"/> Fatigue Face | <input type="checkbox"/> Red, Pale Or Swollen | <input type="checkbox"/> Grunting |
| <input type="checkbox"/> Breathing Faster | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Sucking In Chest/Neck |
| <input type="checkbox"/> Restlessness, Agitation | <input type="checkbox"/> Dark Circles Under Eyes | <input type="checkbox"/> Persistent Coughing |
| <input type="checkbox"/> Complaints Of Chest Pain/Tightness | <input type="checkbox"/> Gray Or Blue Lips Or Fingernails | |
| <input type="checkbox"/> Flaring Nostrils, Mouth Open (Panting) | <input type="checkbox"/> Difficulty Playing, Eating | |
| | <input type="checkbox"/> Difficulty Drinking, Talking | |



Special Care Plan for a Child with Asthma
Medications
For Routine & Emergency Treatment of Asthma

Child's name _____ Date of Birth _____

Name of medications _____

When to use (e.g., symptoms, time of day, frequency, etc.) _____

How to use (e.g., by mouth, by inhaler, with or without spacing device, in nebulizer, with or without dilution, diluting fluid, etc.) _____

Amount (dose) of medication _____

How soon treatment should start to work _____

Expected benefit for the child _____

Possible side effects, if any _____

Date instructions were last updated by child's doctor _____

Name of Doctor (print): _____

Parent's permission to follow this medication plan _____

Parent Signature: _____ Date: _____

Parent Print Name: _____