FORM A-600

Asthma/Reactive Airway Disease (RAD) Individual Child Care Plan

Child's Name: _____ Date of Birth: ___/___/___

Allergies: _____

EMERGENCY PHONE NUMBERS

Parent/Guardian #1: _____
Name Home # Work # Other

Parent/Guardian #2: _____
Name Home # Work # Other

(see emergency contact information for alternate if parents are unavailable)

Primary health provider's name: _____ **emergency phone:** _____

Asthma specialist's name (if any): _____ **emergency phone:** _____

TO BE COMPLETED BY HEALTHCARE PROVIDER

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

colds, tree pollens, grass, aerosol sprays, mold
powder/chalk dust, weather changes, animals, flowers, exercise
strong odors, room deodorizers, smoke, house dust, excitement
foods (specify) _____
other (specify) _____

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

Outdoors
- field trips to see animals/farms
- 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
- pet care
- recent pesticide application in facility
- painting or renovation in facility
- sitting on carpets

Special considerations: related to his/her asthma while at the program? (Check any that apply and describe briefly.)

- ☐ Modified physical activities _____
- ☐ Modified outdoor times or activities _____
- ☐ No animal pets in classroom _____
- ☐ Avoiding certain foods _____
- ☐ Emotional or behavior concerns _____
- ☐ Special consideration while of field trips _____
- ☐ Observation for side effects from medication (see back page).
- ☐ Need to take medication while at the program (see back page).
- ☐ Other _____

Can this child use a **flowmeter** to monitor need for medication in child care? ___ Y ___ N

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 12 months? _____ in the past 3 months? _____

Special physician/parents orders: _____

Medications (routine and emergency): See back page

- Over -

Reminders:

1. *Notify parents immediately if emergency medication is required.*
2. *Get emergency medical help if:*
   - the child does not improve 15 minutes after treatment and family cannot be reached
   - after receiving a treatment for wheezing, the child:
     - is working hard to breathe or grunting
     - is breathing fast at rest (>50/min)
     - won't play
     - is hunched over to breathe
     - is extremely agitated or sleepy
     - has sucking in of skin (chest or neck) with breathing
     - cries more softly and briefly
     - has gray or blue lips or fingernails
     - has trouble walking or talking
     - has nostrils open wider than usual
3. *The child's doctor and the child care facility should keep a current copy of this form in the child's file.*

Physicians: Please be specific.

Medications for routine and emergency treatment of asthma for _____ **(child's name)**

Name of Medication				
When to use give specific symptoms (i.e.: coughing, cold symptoms, wheezing, respiratory rate of ___ per minute)				
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				

Physicians Signature: _____ Date: ___/___/___

Parent/Guardian Signature: _____ Date: ___/___/___

TRAINED CHILD CARE PROVIDERS:

1. _____ Room: _____

2. _____ Room: _____

Plan of care reviewed by:

Director: _____ Date: ___/___/___

Teacher: _____ Date: ___/___/___

Child Care Health Consultant: _____ Date: ___/___/___

Projected date of plan re-evaluation (every six months or sooner if needed): Date: ___/___/___