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 **Medication Consent Form**.

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

- colds
- mold
- exercise
- tree pollens
- dust
- strong odors
- grass
- flowers
- excitement
- weather changes
- animals
- smoke
- foods: _____
- _____
- other: _____
- _____

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

Outdoors

- outdoors on cold or windy days
- jumping in leaves
- animals
- running hard
- gardening
- playing in freshly cut grass
- recent lawn treatment
- other: _____
- _____

Indoors

- kerosene/wood stove
- heated rooms
- painting or renovations
- art projects with chalk, glues
- pet care
- sitting on carpets
- other: _____
- _____

Early Warning Signs for this child's asthma (*circle all that apply*):

- behavior changers, such as nervousness
- rapid breathing
- wheezing, coughing
- stuffy or runny nose
- other: _____
- _____
- headache
- fatigue
- changes in peak flow meter readings
- watery eyes, itchy throat or chin
- _____
- _____

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 **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 that 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, 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:

Virginia Asthma Action Plan

School Division: _____

Name	Date of Birth	Effective Dates / / to / /
Health Care Provider	Provider's Phone	
Parent/Guardian	Parent/Guardian Phone	Parent/Guardian Email:
Additional Emergency Contact	Contact Phone	Contact Email:

GREEN means Go!
Use CONTROL medicine daily
YELLOW means Caution!
Add RESCUE medicine
RED means DANGER!
Get help from a doctor now!

Asthma Severity

☐ **Intermittent** ***or***

Persistent: ☐ Mild ☐ Moderate ☐ Severe

Asthma Triggers (Things that make your asthma worse)

☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust
☐ Animals:_____ ☐ Strong odors ☐ Mold/moisture
☐ Pests (rodents, cockroaches) ☐ Stress/Emotions ☐Exercise
☐Gastroesophageal reflux ☐ Season (circle):Fall, Winter, Spring, Summer
☐ Other:_____

Last Flu Shot: / /

Pneumonia Shot: / /

Green Zone: Go! — Take these CONTROL (PREVENTION) Medicines EVERY Day

You have **ALL** of these:

- Breathing is easy
- No cough or wheeze
- Can work and play
- Can sleep all night

Peak flow in this area:
_____ to _____
(More than 80% of Personal Best)
Personal best peak flow:_____

☐ No control medicines required. **Always rinse mouth after using your daily inhaled medicine.**

☐ _____, ____ puff (s) **MDI with Spacer** __ times a day
Inhaled Corticosteroid or Inhaled corticosteroid/long-acting β-agonist

☐ _____, ____ nebulizer treatment (s) __ times a day
Inhaled Corticosteroid

☐ _____, take ____ by mouth once daily at bedtime
Leukotriene antagonist

For asthma with exercise, ADD:

☐ _____, _____ puffs with spacer 15 minutes before exercise
Fast acting Inhaled β-agonist

For nasal/environmental allergy, ADD:

☐ _____, use _____ spray (s) per nostril _____ times a day
Nasal corticosteroid

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:

- First sign of a cold
- Cough or mild wheeze
- Tight chest
- Problems sleeping, working, or playing

Peak flow in this area:
_____ to _____
(60%-80% of Personal Best)

☐ _____, ____ puffs with spacer every ____ hours as needed
Inhaled b-agonist

☐ _____, ____ nebulizer treatment (s) every ____ hours as needed
Inhaled b-agonist

☐ Other _____

Call your Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work

Red Zone: DANGER! — Continue CONTROL & RESCUE Medicines and GET HELP!

You have **ANY** of these:

- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show

Peak flow in this area:
_____ to _____
(Less than 60% of Personal Best)

☐ _____, __ puffs with spacer **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

☐ _____, __ nebulizer treatment **every 15 minutes**, for **THREE** treatments
Inhaled β-agonist

Call your doctor while administering the treatments.

☐ Other_____

IF YOU CANNOT CONTACT YOUR DOCTOR:
Call 911 for an ambulance,
or go directly to the Emergency Department!

SCHOOL MEDICATION CONSENT AND HEALTH CARE PROVIDER ORDER FOR CHILDREN/YOUTH

CHECK ALL THAT APPLY:

____ **Student has been instructed in the proper use of all of his/her asthma medications, and in my opinion, CAN CARRY AND SELF-ADMINISTER HIS or HER INHALER AT SCHOOL.**

____ **Student is to notify his/her designated school health officials after using inhaler at school.**

____ **Student needs supervision or assistance to use his/her inhaler.**

____ **Student should NOT carry his/her inhaler while at school.**

MD/NP/PA SIGNATURE: _____ **DATE**_____

REQUIRED SIGNATURES:

I give permission for school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child.

PARENT/GUARDIAN _____ **Date** _____

SCHOOL NURSE/DESIGNEE _____ **Date** _____

OTHER _____ **Date** _____

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 4/11
Based on NAEPP Guidelines and modified with permission from the D.C. Asthma Action Plan via District of Columbia Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership