Asthma Action Plan for: Room

These forms must be updated by child's physician every 6 months.

Name of person completing form:	Today's date:
Child's full name:	Date of birth:
Parent/guardian:	Phone:
Primary Health Care Professional name:	Phone:
Primary Health Care Professional signature:	

Asthma Triggers (Avoid exposure to triggers)

- ☐ Carpet
- ☐ Animals
- ☐ Pollen
- ☐ Other:
- ☐ Mold
- ☐ Tobacco smoke
- ☐ Dust (mites)
- ☐ Cockroaches
- ☐ Chemical sprays
- ☐ Strong odors
- ☐ Changes in weather
- ☐ Illness

Severity of asthma

- ☐ Mild intermittent
- ☐ Mild persistent
- ☐ Moderate persistent
- ☐ Severe persistent

List Allergies:

Consult with a Child Care Health Consultant about this plan.

GREEN - GO
Child is breathing well.

Use these long-term CONTROL medicines **every day** to keep child in the green zone.

No cough or wheeze.

Plays actively.

Sleeps well at night. **No early warning signs.**

Medicine:	How much to give:	When to give:
USE AT: ☐ **Home** ☐ **School**		

Medication before active play or exercise: ☐ None needed

☐ Medication _____ Give _____ minutes before active play or exercise.

YELLOW - CAUTION

Child has some problems breathing.

Keep using long-term CONTROL green zone medicines every day. Add quick-relief medicines to keep asthma from becoming worse. Parent/legal guardian contacts the Health Care Professional when quick-relief medicine is used more than twice in a week.

- **Coughing**
- **Wheezing**
- **May Squat or hunch over**
- **Chest Tight**
- **Waking Often**
- **Poor appetite**
- **Decreased Play or activity**

Other Early Symptoms (CHILD SPECIFIC):

At Home

Medicine:	How much to give:	When to give:
Albuterol _____	☐ 2 puffs by inhaler (with spacer)	Give first dose as soon as possible. Repeat every ____ minutes for up to a total of ____ doses if needed.
OR:	☐ by nebulizer (with mask)	

If symptoms return to Green Zone:	If symptoms **do not return** return to Green Zone within 1-2 hour::
• Take quick-relief medicine every 4 hours for _____ days. • Change long-term control medicines to _____ for _____ days. • Contact Health Care Professional for follow-up care if symptoms return.	Take quick-relief medication again. Contact Health Care Professional.

Child's Photo

At Child Care

Medicine:	How much to give:	When to give:
Albuterol _____ OR:	☐ 2 puffs by inhaler (with spacer) ☐ by nebulizer (with mask)	Give first dose as soon as possible. Call parent/guardian if symptoms do not return to green zone within 15 minutes. Repeat every _____ minutes for up to a total of _____ doses if needed.

If symptoms return to Green Zone:	If symptoms **do not return** return to Green Zone within 1 hour::
• Continue quick-relief medicine every 4 hours for remainder of time in care.	Have parent/guardian pick child up and care for child

See page 2 for RED – DANGER: Child has severe problems with breathing.

Asthma Action Plan for: Room

RED – CAUTION Child has severe problems with breathing.	Get help! Give quick-relief medicines until help arrives.		
Severe Symptoms • Getting worse instead of better. • Coughing constantly. • Cannot talk well. • Cannot play or walk. • Breathing is hard and fast, gasping. • Nostrils open wide when child breathes. • Chest muscles tight. Space between the ribs and over the chest bone suck in with each breath. • Fingernails or lips blue.	**CHILD HAS SEVERE SYMPTOMS!**  **CALL 9-1-1** if symptoms last more than a few minutes.	**At Home**		
		Medicine:	**How much to give:**	**When to give:**
		Albuterol _____ OR:	☐ 2 puffs by inhaler (with spacer) ☐ by nebulizer (with mask)	• Give a dose immediately and call Health Care Professional. • Repeat every ____ minutes until medical help is obtained. • **Do not leave child alone.**
		At Child Care		
		Albuterol _____ OR:	☐ 2 puffs by inhaler (with spacer) ☐ by nebulizer (with mask)	• Give a dose immediately. • Call parent/guardian if not previously called. • Call Health Care Professional if unable to reach parent/guardian. • Repeat dose every _____ minutes until medical help is available. • **Do not leave child alone.**

Plan reviewed by:

Child Care Director/Operator name:	Date:
Signature:	
Child Care Health Consultant name:	Date:
Signature:	

Child care staff trained to care for child:

#1:	#2:	#3:
Who will move and/or care for other children?		
Who will notify the child's parents?		
Who will call and assist EMS (911) when needed?		
Who will go to the hospital when needed and stay with child until parent/legal guardian assumes responsibility?		

Parent Form - Must be filled in by parent and resubmitted every six months.

Calvary
Child Development Center

Medical Authorization

CCDC MEDICATION/CARE AUTHORIZATION AND RELEASE

Child's Name: _____ Age: ___ _____

☐ *For children with Food or Non-Food allergies, please check.* I acknowledge that Calvary Church ("Calvary"), including Calvary Child Development Center ("CCDC"), not an allergen-free facility, that CCDC cannot guarantee my child will not be exposed notwithstanding awareness of his/her allergies, and he/she may be exposed to an allergen while on-site at CCDC.

For All Medical Action Plans (Food Allergy, Non-Food Allergy, Seizure, or Asthma)
I hereby give permission for my child, while present at CCDC, to receive medication in accordance with the Medical Action Plan for my child or as otherwise indicated below, as prescribed by a licensed physician. I hereby authorize CCDC, including its directors, staff and volunteers, to administer mediation and to provide or arrange for medical care in accordance with the Medical Action Plan or as indicated below.

For myself and for my child, I release and discharge CCDC, Calvary, its officers, elders, employees, volunteers or other agents from all claims and liability for any loss or injury that may occur in the future as a result of exposure to allergens and any medications or care provided under this authorization and release. I further agree to reimburse, indemnify and hold Calvary and CCDC harmless from any and all costs, claims and liabilities associated with providing or arranging medical care for my child.

Parent/Guardian: _____ Signature:_____ Date: _____

Address: _____ Phone_____

Medical Need	Medication	Method of Application	Dosage	Prescribed By
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____