JACK & JiLL
EARLY CHILDHOOD LEARNING

ASTHMA/REACTIVE AIRWAY DISEASE (RAD)

INDIVIDUAL CHILD CARE PLAN

Child's Name ______________________ **Date of Birth** (mm/dd/yyyy) ______________

Allergies ____

1 PARENT/GUARDIAN

Name ______________________
Cell Phone ______________________
Work Phone ______________________
Other (home) ______________________

2 PARENT/GUARDIAN

Name ______________________
Cell Phone ______________________
Work Phone ______________________
Other (home) ______________________

Primary health care provider's name: ______________________ emergency phone: ______________

Specialist's Name (if any): ______________________ emergency phone: ______________

TO BE COMPLETED BY HEALTH CARE PROVIDER

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

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

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

- ☐ 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) ______________________
- ☐ kerosine/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 animals/pets in classroom ______________________
- ☐ Avoiding certain foods ______________________
- ☐ Emotional or behavior concerns ______________________
- ☐ Special consideration while on 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? ____Yes ____No

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/parent orders: ______________________

Medications (routine and emergency): See back page

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ASTHMA/REACTIVE AIRWAY DISEASE (CONTINUED)

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 is 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.

Medications for routine and emergency treatment of asthma for: ______________________				
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				
Possibly side effects, if any				

X

______________________________ ____________

Physician's Signature **Date**

______________________________ ____________

Parent/Guardian Signature **Date**

The parties agree that this agreement may be electronically signed. The parties agree that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

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:______________________

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