

Asthma Care Plan

Facility Name: _____

Emergency Plan for: _____
Facility Address: _____

Child's Full Name: _____

Date of Birth: _____

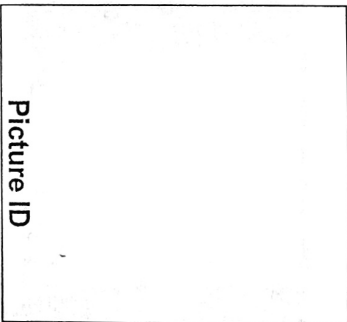
Parent/Guardian: _____

Phone (home/cell): _____ Phone (work): _____

Emergency Contact: _____

Phone (home): _____ Phone (work): _____

Primary Care Provider: _____ Office Phone: _____



Picture ID

• GIVE _____
(name of medication)

• Follow Instructions: _____

CHILD'S ASTHMA TRIGGERS ARE:

- | | | | | | | |
|--|---|---|----------------------------------|--------------------------------|--|---------------------------------|
| <input type="checkbox"/> change in temperature | <input type="checkbox"/> colds, infection | <input type="checkbox"/> dust, mites (e.g. upset) | <input type="checkbox"/> emotion | <input type="checkbox"/> mould | <input type="checkbox"/> physical activity | <input type="checkbox"/> pollen |
| <input type="checkbox"/> animals | (list): _____ | | | | | |
| <input type="checkbox"/> foods | (list): _____ | | | | | |
| <input type="checkbox"/> strong smells | (list): _____ | | | | | |
| <input type="checkbox"/> Other: _____ | | | | | | |

CHILD'S ASTHMA SYMPTOMS ARE USUALLY:

- | | |
|---|--|
| <input type="checkbox"/> appears anxious | <input type="checkbox"/> short of breath |
| <input type="checkbox"/> coughing | <input type="checkbox"/> wheezing |
| <input type="checkbox"/> difficulty talking | <input type="checkbox"/> in-drawing/tracheal tug |
| <input type="checkbox"/> fast/shallow breathing | <input type="checkbox"/> other (list below): _____ |
| <input type="checkbox"/> pale | <input type="checkbox"/> _____ |
| <input type="checkbox"/> hunched over | <input type="checkbox"/> _____ |

CHILD'S EMERGENCY TREATMENT:

- ☐ Medication is stored: _____
- ☐ Medication expiry date: _____
- ☐ Names of staff oriented to plan: _____
- ☐ Emergency plan review date (to do yearly): _____
- ☐ Field Trip Plans: _____

- If unsure, child is worse or not getting better CALL 911
- CALL PARENTS

It is the parent's responsibility to notify the facility of any change in the child's condition.

Sign below if you agree with above Information & Plan:

Primary Care Provider _____ Date _____

Parent/Guardian _____ Date _____

Childcare Supervisor/School Personnel _____ Date _____

Asthma Care Plan is provided as a resource from Vancouver Coastal Health – February 2011