Community Action Team
CHILD & FAMILY DEVELOPMENT PROGRAMS

Asthma Information Plan

CHILD INFORMATION

Child's Name: _____ Date: _____

Child's DOB: _____ Center: _____

CONTACT INFORMATION

Parent/Guardian's Name _____ Telephone _____

Parent/Guardian's Name _____ Telephone _____

Primary Health Care Provider _____ Telephone _____

Specialist (if applicable) _____ Telephone _____

Parent/Guardian will be notified immediately of any suspected allergic reactions, or if the child came in contact with the allergen even if a reaction did not occur.

CHILD'S ASTHMA INFORMATION

1. Describe signs and symptoms:

_____

_____

2. What are your child's early warning signs of an asthma attack? Check all that apply:

□ Cough
□ Cranky
□ Runny Nose
□ Eating Less
□ Less Active
□ Wheezing
□ Runny/Itchy Eyes
□ Throwing Up
□ Sleeping Issues

3. How to avoid or prevent an asthma episode:

_____

_____

4. What triggers your child's asthma? Check all that apply:

□ Cold/Respiratory Infection
□ Strong Odors
□ Hard Exercise/Activity
□ Weather Changes
□ Cold Air
□ Pollen
□ Smoke
□ Animals

5. Are there any special considerations that your child may need while at the center/school related to his/her asthma?

_____

_____

MEDICATION(S) FOR ASTHMA – Prescribed and Over-the-Counter

List medication(s) to be given during school or for an emergency:

Name of Medication	Dosage	Directions	Expiration Date

EMERGENCY RESPONSE PLAN

1. Describe symptoms that would prompt emergency medication to be given:

2. List steps and procedures to follow during an emergency related to the child's special medical condition:

TRAINING FOR STAFF

List training required for staff prior to child attending:

SIGNATURES		**DATE**
Parent/Guardian's:		
Head Start Staff:		
Health Care Provider:		