

YWCA Kidslink Asthma Care Plan

Child's Name:		Kidslink Program:		DOB:		
Parent/Guardian Name & Emergency Numbers						
Name		Phone		Name		
Phone		Phone		Phone		
Medical Personnel Name & Emergency Numbers						
Physician		Phone		Asthma Specialist		
Phone		Phone		Phone		
Known Triggers for this child's asthma (Circle all that apply)	colds strong odors weather changes animals		exercise tree pollens grass/flowers room deodorizers smoke		dust excitement mold	
	Foods (specify) Other (specify)					
Activities for which this child has needed special attention in the past (Circle all that apply)	Outdoors Field trips to see animals Running hard Gardening Jumping in leaves Outdoors on cold or windy days Playing in freshly cut grass Other:			Indoors Art projects with chalk, glue, fumes Sitting on carpets Pet care Recent pesticides application in facility Painting or renovation in facility Other:		
	Is this child on any medications presently? If yes, what are the medications and how often are they given?					
Will medication ever be needed during child care hours? YES NO 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? _____						
Typical Signs and Symptoms of the child's asthma episodes (Circle all that apply)	Fatigue Breathing faster Restlessness, agitation Complaints of chest pain/tightness Flaring nostrils, mouth open (panting)		face red, pale, swollen wheezing dark circles under eyes		grunting sucking in chest/neck persistent coughing gray or blue lips or fingernails difficulty playing, eating, drinking, talking	
	Reminders: 1. Notify parents immediately if emergency medication is required 2. Get emergency medical help if: *The child does not improve in 15 minutes after treatment and family cannot be reached *After receiving treatment for wheezing the child: *Is working hard to breathe or grunting *won't play *is breathing fast at rest (greater than 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 extremely agitated or sleepy *has sucking in of skin (chest or neck) with breathing 3. Child's doctor & child care facility should keep a current copy of this form in child's record.					

Signature of Authorized Prescriber _____ Date _____

Signature of Parent _____ Date _____

Signature of all staff caring for this child: