SONCCA
ASTHMA SPECIAL CARE PLAN

Child's Name: _____Date of Birth: _____

Typical signs and symptoms of the child's asthma episodes (check all that apply):

___fatigue
___flaring nostrils, mouth opens (panting)
___dark circles under eyes
___gray or blue lips or finger nails
___persistent cough
___difficulty playing, eating, drinking, talking
___wheezing
___restlessness/agitation
___red face, pale or swollen
___grunting
___sucking in chest/neck
___complaint chest pains/tightness
___breathing faster
___other:_____

Steps to take during an asthma episode:

1. Give medications as listed below*.

Special Instructions:

_____
_____
_____
_____

Emergency Asthma Medications

Name of Medication	Amount	When to Use
1.		
2.		
3.		

**Authorization for the Administration of Medication form must be on file for each medication.*

2. Check for decreased symptoms.
3. Contact parent/guardian immediately if emergency medication is required.
4. Call 911 if:
- **a.** The child has not improved in 15 min. after treatment and family can not be reached.
- **b.** After receiving a treatment for wheezing, the child:

- Is working hard to breathe or grunting
- Is breathing fast at rest(>50/min)
- Has trouble walking or talking
- Have nostrils open wider than usual
- Won't play
- Has gray or blue lips/finger nails
- Cries more softly and briefly
- Is hunched over to breathe
- Is extremely agitated or sleepy

Has sucking in of the skin (chest/neck) with breathing

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5. If no medication is needed while the child is attending the program, please have the doctor initial below.

_____No medication required while attending child care program
**Doctors initials are required*

Physician's name:
_____

Physician's signature:
_____

Phone number: (_____) - _____ Date: _____

Parent's name: _____Parent's signature: _____

Staff Signatures:

_____Authorization for the Administration of Medication form and medication on site

I have read and understand the attached Asthma Care Plan for: _____
(Child's Name)

Teacher's Name: _____Teacher's Signature: _____

Teacher's Name: _____Teacher's Signature: _____

Teacher's Name: _____Teacher's Signature: _____

Teacher's Name: _____Teacher's Signature: _____

Teacher's Name: _____Teacher's Signature: _____

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Child's Name: _____Date of Birth: _____

Teacher's Name: _____Teacher's Signature: _____

Teacher's Name: _____Teacher's Signature: _____

Teacher's Name: _____Teacher's Signature: _____

Child Care Director: _____Date: _____

Child's doctor and Child Care facility should keep a current copy of this form in child's record.