



BOYS & GIRLS CLUB
OF BRISTOL

Asthma Care Plan For Child Care Settings

Child's Name: _____		Date of Birth: _____
Parent/Guardian's Name: _____		
Emergency Phone #s: _____	Mother: _____	Father: _____
(see emergency contact information for alternates if parents are unavailable)		
Primary Health Care Provider's Name: _____		Primary Health Care Provider's Phone #: _____
Asthma Specialist's Name (if any): _____ Asthma Specialist's Provider's Phone #: _____		

Known Trigger's (for a child with asthma check all that apply)

- | | | | | | |
|---|----------------------------------|--|---------------------------------------|--|-------------------------------|
| <input type="checkbox"/> Colds | <input type="checkbox"/> Mold | <input type="checkbox"/> Exercise | <input type="checkbox"/> Tree Pollens | <input type="checkbox"/> Excitement | <input type="checkbox"/> Dust |
| <input type="checkbox"/> Strong Odors | <input type="checkbox"/> Animals | <input type="checkbox"/> grass/flowers | <input type="checkbox"/> Smoke | <input type="checkbox"/> Weather Changes | |
| <input type="checkbox"/> Room Deodorizers | | | | | |

Foods (specify): _____

Other (specify): _____

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

Outdoor	Indoor
<input type="checkbox"/> Field Trip to see animals	<input type="checkbox"/> Kerosene/wood stove heated rooms
<input type="checkbox"/> Gardening	<input type="checkbox"/> art projects with chalk, glue, fumes
<input type="checkbox"/> Outdoors on cold/windy days	<input type="checkbox"/> sitting on carpets
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> pet care
<input type="checkbox"/> Running Hard	<input type="checkbox"/> recent pesticide application
<input type="checkbox"/> Jumping in leaves	<input type="checkbox"/> painting or renovation in facility
<input type="checkbox"/> Playing in fresh cut grass	

Is the child on any medication presently? _____

If yes, what are the medications and how often are they given? _____

Will the medication ever be needed during child care hours? ☐ Yes ☐ No

How often has your child needed urgent care from a doctor for an attack of asthma:

In the past 12 months? _____ In the past 3 months? _____

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

- | | | | | | |
|---|--|---|-----------------------------------|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> grunting | <input type="checkbox"/> Breathing faster | <input type="checkbox"/> Wheezing | <input type="checkbox"/> sucking in chest/neck | <input type="checkbox"/> face red, pale swollen |
| <input type="checkbox"/> Restlessness/Agitation | <input type="checkbox"/> Dark Circles Under eyes | <input type="checkbox"/> Persistent coughing | | | |
| <input type="checkbox"/> Complaints of chest pain/tightness | <input type="checkbox"/> gray or blue lips or finger nails | <input type="checkbox"/> Flaring nostrils, mouth open | | | |
| <input type="checkbox"/> Difficult playing, eating, drinking, talking | | | | | |

Reminders:

1. Notify Parents immediately if emergency medication is required
2. Get emergency 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 breath or grunting
 - Has gray or blue lips/fingernails
 - Has nostrils open wider than usual
 - Is breathing fast at rest (greater than 50/min)
 - Has trouble walking or talking
 - Has sucking in of skin (chest or neck) with breathing
 - Won't play
 - Cries more softly and briefly
 - Is extremely agitated or sleepy
3. Child's physician and child care facility should keep a current copy of this form in child's record.

Signature of authorized prescriber: _____ Date: _____

Signature of Parent: _____ Date: _____

Signatures of all staff caring for this child: _____



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Administration of Asthma Medication

1. Check the order thoroughly
2. Look at the child, call their name out loud and tell them the medication you are giving them (ie: Susan Smith, I am going to give you your albuterol inhaler for your asthma)
3. Go through the 5 Rights (CTDMR) Child, Time, Dose, Medication, Route

Inhaler

1. Shake the inhaler well immediately before each use.
2. Have the child breathe out fully through their mouth and then put their mouth on the mouth piece and breathe slowly in as you depress and then immediately release the top of the metal canister.
3. If the order requires a spacer for the medication you must use this when administering the medication.
4. When a child is breathing in while using a spacer and a "note" or squeak is heard, they are inhaling too fast. They must be instructed to breathe slower. If they inhale too fast, they will not get the proper amount of medication.
5. After every use of the inhaler, rinse the mouth piece with warm running water for 30 seconds then shake to remove excess water.
6. Soak the spacer and mask for fifteen minutes in luke warm water with liquid detergent, agitate gently, rinse with clean water, shake and allow to air dry in vertical position.
7. Chart on the medication form that the medication was given.

Nebulizer

1. Put the correct medication in the reservoir.
2. Use the proper mouth piece the doctor has ordered for the child (plastic tube, mask, or T-piece).
3. Turn the machine (nebulizer) on.
4. When the fluid in the reservoir is completely gone, the treatment is finished.
5. Rinse out all pieces of the equipment used with hot soapy water, rinse with water and let air dry after each use.
6. Do not rinse out the clear plastic tubing that connects the machine to the mouth piece equipment. The clear plastic tubing should be clear and patent. If not, the parents need to replace.
7. Chart on the medication form that the medication was given.