

Special Health Care Plan for a Child with Asthma

Working in collaboration with the child's parent and Health Care Provider, the following health care plan was developed to meet the needs of:

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| Child's name: | Child's date of birth: |
| Name of child's Health Care Provider: | <input type="checkbox"/> Physician <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Nurse Practitioner |

Describe the special health care needs of this child and the plan of care as identified by the parent and child's health care provider. This should include information completed on the Medical Statement.

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| Medications at home: |
| Medications at child care: |
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| Emergency Plan: |
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Information specific to this child's asthma:

Known Triggers for this child's asthma (circle all that apply):

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|-------------------|-----------------|---------------|-------------|
| colds | mold | exercise | tree pollen |
| dust (dust mites) | strong odors | grass | flowers |
| excitement | weather changes | animal dander | smoke |
| foods (specify): | | | |
| other (specify): | | | |

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

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| Outdoors | Indoors |
| field trip to see animals | kerosene/wood stove heated rooms |
| running hard | painting or renovations |
| gardening | art projects with chalk, glues, painting |
| jumping in leaves | pet care |
| outdoors on cold/windy days (recent only) | pesticide application |
| playing in freshly cut grass | sitting on carpets |
| other (specify): | other (specify): |

Signs & Symptoms this child displays during an asthma episode (circle all that apply):

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|-------------------------------|---|--------------|
| fatigue | face red, pale or swollen | grunting |
| breathing faster | wheezing | restlessness |
| dark circles under eyes | sucking in chest/neck | agitation |
| persistent coughing | complaints of chest pain/tightness | |
| gray/blue lips or fingernails | difficulty playing, eating, drinking, talking | |
| other (specify): | | |

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|---------------------|
| Child's name: _____ |
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Staff to care for child and staff training:

Identify the program staff that will care for this child with asthma:

| Staff name: | Credentials or professional license information* |
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Describe any additional training, procedures, or competencies that the staff identified will need to carry out the health care plan as identified by the parent or health care provider. This should include information from the Medical Statement or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

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Signature of Authorized Program Representative

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR, and First Aid certifications or have a license that exempts them from training and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

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|---|---------------------|----------------------------|
| Provider/Facility name: | Facility ID number: | Facility telephone number: |
| Authorized child care provider name (please print): | | Date: |
| Authorized child care provider signature: | | |
| Parent/Guardian name (please print): | | Date: |
| Parent/Guardian signature: | | |