College of Southern Idaho Head Start/ Early Head Start

Child Asthma/ Health Plan

Child's Name_____ Date of Birth:_____

Center _____ Classroom Family Educator_____

Medial Provider_____ Phone Number_____

Parent's Name_____ Phone Number_____

Are there any program areas that will need to be changed to accommodate your child? (outdoor activities, field trips, nutrition, classroom environment, transportation)

Asthma Triggers	Warning signs of an asthma attack
Colds or respiratory infections Weather changes Strong emotions Fireplace or woodstove Hard exercise/ activity Strong odors Cigarette smoke Pollen Food (list) _____	Cough Runny nose Working harder to breathe Throwing up Cranky Eating less Trouble sleeping Wheezing Less running/ playing Itch, watery eyes
Food Allergies- *Fill out Medical Statement for Food Substitution Form*	

Medication to be given in the classroom –have physician fill out - *Physician's Medication Orders for school Administration Form with parent's signature*					
Medication to be given in the classroom					
Daily medication	reason	dose	How given(by mouth, on skin, nebulizer, etc)	schedule	Possible side effects

Emergency Plan for Severe Allergic Reaction

If the child develops signs of severe allergic reaction such as:
Hives, itching, flushed face or skin, swelling of face, lips, mouth, vomiting, diarrhea,
Unusual posture (hunched shoulders) , nasal flaring, breathing through the mouth, difficulty talking or breathlessness, retractions (skin between ribs above and below breast bone pulls inward when breathing).

Changes in skin color- blue, gray around the mouth, fingernails (very serious sign) Peak flow numbers very low; child may be unable to blow at all (more than 40% drop)

The classroom team will implement the following emergency plan:
___Administer prescribed Epi- Pen immediately
___Administer other prescribed medication:_____
(Medication and dosage)

_____
(Medication and dosage)

Circle/check all that apply:

1) Call 911 2) Call Parent 3) Call Child's physician 4) stay with child at all times

I agree with the above classroom Asthma / Health Plan

_____ _____
Parent/ Guardian signature Date

_____ _____
Classroom Family Educator Signature Date

_____ _____
Center Supervisor Signature Date

_____ _____
Nurse Signature Date

_____ _____
CSI Health Specialist Signature Date

Original to Health Specialist 1 Copy to Child's File 1 Copy to Emergency Book