This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Asthma Care Plan Request Form

Child's name: _____

Child's date of birth: _____

Early Learning or Child Care Program Director: _____

Early Learning or Child Care Program: _____

Mailing Address: _____

Phone Number: _____

Fax Number: _____

Healthcare Provider: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans. **Please complete pages 2-5**. These are forms that require a healthcare provider's instructions and signature.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

Parent or Guardian Phone Number: _____

My Asthma Plan ENGLISH

Patient Name: _____

Medical Record #: _____

Provider's Name: _____ DOB: _____

Provider's Phone #: _____ Completed by: _____ Date: _____

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day **EVERY DAY!**	☐ Gargle or rinse mouth after use
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	
		_____ times per day **EVERY DAY!**	

Quick-Relief Medicines	How Much to Take	How Often	Other Instructions
	☐ 2 puffs ☐ 4 puffs ☐ 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am *doing well,* *getting worse,* *having a medical alert.*

GREEN ZONE

Doing *well.*

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

Peak Flow (for ages 5 and up):
is _____ or more. (80% or more of personal best)

Personal Best Peak Flow (for ages 5 and up): _____

PREVENT asthma symptoms every day:

☐ Take my controller medicines (above) every day.

☐ Before exercise, take _____puff(s) of _____

☐ Avoid things that make my asthma worse. (See back of form.)

YELLOW ZONE

Getting *worse.*

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
_____ to _____(50 to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

☐ Take___puffs or ☐ one nebulizer treatment of quick relief medicine. If I am not back in the ***Green Zone*** within 20-30 minutes take ___more puffs or nebulizer treatments. If I am not back in the ***Green Zone*** within one hour, then I should:

☐ Increase_____

☐ Add_____

☐ Call_____

☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _____(50% of personal best)

MEDICAL ALERT! Get help!

☐ Take quick relief medicine: _____puffs every _____minutes and get help immediately.

☐ Take _____

☐ Call _____

Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ☐ Yes ☐ No self administer asthma medications: ☐ Yes ☐ No (This authorization is for a maximum of one year from signature date.)

X _____ Healthcare Provider Signature

X _____ Date

Controlling Things That Make Asthma Worse

☐ SMOKE

- Do not smoke. Attend classes to help stop smoking.
- Do not allow smoking in the home or car. Remaining smoke smell can trigger asthma.
- Stay away from people who are smoking.
- If you smoke, smoke outside.

☐ DUST

- Vacuum weekly with a vacuum with a high efficiency filter or a central vacuum. Try to make sure people with asthma are not home during vacuuming.
- Remove carpet if possible. Wet carpet before removing and then dry floor completely.
- Damp mop floors weekly.
- Wash bedding and stuffed toys in hot water every 1-2 weeks. Freeze stuffed toys that aren't washable for 24 hours.
- Cover mattresses and pillows in dust-mite proof zippered covers.
- Reduce clutter and remove stuffed animals, especially around the bed.
- Replace heating system filters regularly.

☐ PESTS

- Do not leave food or garbage out. Store food in airtight containers.
- Try using traps and poison baits, such as boric acid for cockroaches. Instead of sprays/bombs, use baits placed away from children, such as behind refrigerator.
- Vacuum up cockroach bodies and fill holes in with caulking or copper wool.
- Fix leaky plumbing, roof, and other sources of water.

☐ MOLD

- Use exhaust fans or open windows for cross ventilation when showering or cooking.
- Clean mold off hard surfaces with detergent in hot water and scrub with stiff brush or cleaning pad, then rinse clean with water. Absorbent materials with mold may need to be replaced.
- Make sure people with asthma are not in the room when cleaning.
- Fix leaky plumbing or other sources of water or moisture.

☐ ANIMALS

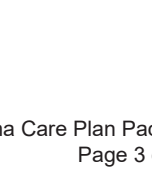
- Consider not having pets. Avoid pets with fur or feathers.
- Keep pets out of the bedroom of the person with asthma.
- Wash your hands and the hands of the person with asthma after petting animals.

☐ ODORS/SPRAYS

- Avoid using strongly scented products, such as home deodorizers and incense, and perfumed laundry products and personal care products.
- Do not use oven/stove for heating.
- When cleaning, keep person with asthma away and don't use strong smelling cleaning products.
- Avoid aerosol products.
- Avoid strong or extra strength cleaning products.
- Avoid ammonia, bleach, and disinfectants.

☐ POLLEN AND OUTDOOR MOLDS

- Try to stay indoors when pollen and mold counts are high.
- Keep windows closed during pollen season.
- Avoid using fans; use air conditioners.



☐ COLDS/FLU

- Keep your body healthy with enough exercise and sleep.
- Avoid close contact with people who have colds.
- Wash your hands frequently and avoid touching your hands to your face.
- Get an annual flu shot.

☐ WEATHER AND AIR POLLUTION

- If cold air is a problem, try breathing through your nose rather than your mouth and covering up with a scarf.
- Check for Spare the Air days and nights and avoid strenuous exercise at those times.
- On very bad pollution days, stay indoors with windows closed.

☐ EXERCISE

- Warm up before exercising.
- Plan alternate indoor activities on high pollen or pollution days.
- If directed by physician, take medication before exercise. (See Green Zone of Asthma Action Plan.)

This page to be completed by:
Healthcare Provider

Public Health
Seattle & King County

3-Day Critical Medication Authorization Form

Healthcare Provider and Parent or Guardian: In the event the child needs to remain at the program past usual hours, a 3-day supply of Critical Medication(s) must be kept at the program. This life-sustaining medication is usually given when the child is not in care. Examples may include certain diabetes, seizure, or asthma medications. A new 3-Day Critical Medication Authorization Form should be completed if there are changes to the medication or child's health condition.

Program Staff: This life-sustaining medication will only be given if the child needs to remain at the program past usual hours. Each 3-Day Critical Medication must have its own 3-Day Critical Medication Authorization Form. Never give an expired medication. An expired medication must be replaced, and the updated expiration date must be added to this form.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Reason for medication: _____

Possible side effects of medication: _____

Medication expiration date: _____

When to give medication (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication)**:** _____

How much medication to give (must include dose of medication)**:** _____

How long to give medication (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year)**:** _____

How to give the medication (for example: by mouth [oral], on skin [topical], injection, etc.)**:** _____

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3-Day Critical Medication Authorization Form (Continued)

Medication requires special storage: ☐ Yes ☐ No

If yes, specify (for example: refrigerate; keep away from light; etc.)**:**_____

Additional instructions: _____

Parent or Guardian: By signing below, I give the program permission to give this medication to my child as described on this 3-Day Critical Medication Authorization Form.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

Healthcare Provider: By signing below, I acknowledge that this child requires a 3-Day supply of Critical Medication to be stored at the child's program**. It will only be given in the event the child needs to remain at the program past usual hours.**

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Additional Requirements for Care Plans

Child's name: _____

Program Staff and Parent or Guardian: The WAC requires that all care plans include the potential side effects and expiration date of medications. If this is not included in the care plan, write them in the table below. **You may find this information on the medication packaging or label.**

Medication Name	Expiration Date	Potential Side Effects

Program Staff and Parent or Guardian: The WAC requires a parent**,** guardian, or appointed designee to provide training to program staff about medication administration or special medical procedures listed in the child's care plan. **Use the space below to document this training.**

Employee Training Record				
Date of Training	**Employee Name (Printed)**	**Employee Signature**	**Trainer Name (Printed)**	**Trainer Signature**

Program Staff and Parent or Guardian: The WAC requires written consent from a child's parent or guardian before a program can administer any medications or follow a care plan that is completed by a healthcare provider. **Please have the parent or guardian sign below.**

By signing below, I give the program permission to follow this care plan as ordered by the healthcare provider.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

This page to be completed by:
Parent or Guardian

Public Health
Seattle & King County

Emergency Contact Information

Child's name: _____

Parent or Guardian: If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

Emergency Contact #1

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #2

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #3

Name: _____

Relationship to Child: _____

Phone Number: _____

This page to be completed by:
Program Staff

Public Health
Seattle & King County

Medication Log

Program Staff: Please print a Medication Log for each medication (including any 3-Day Critical Medication).

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Date	Time	Dose	Person Giving Medication (*Initials)	Reason Medication Was Not Given	Observed Side Effects

Initials*	Printed Name and Signature of Person Giving Medications