Kids Go Further
AYS
AT YOUR SCHOOL

Plan of Care for Asthma

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

AYS Program: _____ **School Year:** _____

Please list the name and phone number of the physician your child sees for asthma below:

_____ _____

Name (please print) Physician's Phone Number

Does your child take prescription medication for the prevention or treatment of their asthma? ☐ YES* ☐ NO

If your child participated in an outside activity or field trip would they be required to take any medications with them for prevention of an asthma attack: ☐ YES* ☐ NO

(* If you answered **yes** to either of the above questions Please list the medications your child takes for prevention/ treatment of asthma below)

Name of Medication(s)	Dosage	Time(s) of Day Given

Would any of the above medication(s) need to be given during normal program hours? ☐ YES ☐ NO

Would any of the above medication(s) need to be given during extended program hours? ☐ YES ☐ NO

If you answered **yes** to either question, please be aware that an AYS Medication Consent form will need to be completed by your child's doctor and provided to AYS.

Have you provided an AYS Medication Consent form to AYS staff? ☐ YES ☐ NO

In order to assist AYS in the care of your child please identify the things that could cause an asthma attack for your child: (Check any that apply to your child)

☐ Animals ☐ Tobacco Smoke ☐ Chalk dust ☐ Change in Temperature

☐ Dust Mites ☐ Exercise ☐ Outdoor Air Pollution ☐ Molds

☐ Pollens ☐ Respiratory Infections ☐ Smoke ☐ Strong odors

☐ Insects ☐ Allergies_____

☐ Other _____

Control of the Program Environment

Please list any steps, measures, restrictions or anything that your child could require to avoid an asthma attack.

_____

_____

_____

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Please indicate your child's symptoms of an asthma attack: (Check any that apply to your child)

- ☐ Difficulty breathing
- ☐ Coughing
- ☐ Wheezing
- ☐ Grunting
- ☐ Chest feels tight
- ☐ Cannot catch their breath
- ☐ Nostril flaring
- ☐ Hunches over to breathe easier
- ☐ Speaks in very short, choppy sentences
- ☐ Skin, lips and/or fingernails look gray, blue or purple
- ☐ Shortness of breath
- ☐ Retractions of the areas over the stomach and/or ribs
- ☐ Other_____

The usual procedure at AYS for a child having an asthma attack is as follows:

Remove child from the environment of his/her trigger agents. Let the child find a position comfortable to him/her. Attempt to calm and reassure the child. Assess for the severity of the attack. If parents have pro vided a peak flow meter, take a reading and compare to child's desired peak flow reading. Give emergency medications listed previously. Check for decreased symptoms and/or increased peak flow reading. Con tact parent/guardian. Seek Emergency Medical Services if child is not improving.

If there are any special instructions different from those above please list them below: _____

_____

_____

_____

Emergency Asthma Medication:

Does your child require carrying an asthma inhaler or other emergency medication? ☐ YES ☐ NO

Did you indicate on the previous page that medication(s) information? ☐ YES ☐ NO

Did you provide AYS with an emergency asthma inhaler or other emergency medication? ☐ YES ☐ NO

Does your child have your permission to carry their own emergency asthma inhaler? ☐ YES ☐ NO

1. Has your child demonstrated the correct use of the inhaler? ☐ YES ☐ NO
2. Does your child agree to never share or misuse inhaler? ☐ YES ☐ NO
3. Does your child agree that after two puffs, if there is not improvement, he/she will tell the director so that parents can be notified? ☐ YES ☐ NO

Review of above information and signatures for the _____ school year in AYS.

_____ _____

Parent/Guardian Signature | AYS Program Director's Signature

_____ _____

Date | Date

Review of above information and signatures for the _____ school year in AYS.

_____ _____

Parent/Guardian Signature | AYS Program Director's Signature

_____ _____

Date | Date

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