

Individualized Health Care Plan (IHCP): Asthma

Child Care Program: _____

Date of plan: _____

Child's Name: _____ **DOB:** _____ **Room** _____ **Teacher (s)** _____

Address: _____

Parents' daytime contact phone numbers:.

Mother/Guardian: Name: _____

Primary Language: Child: _____ Family: _____

(H) _____ (W) _____ (cell) _____

Diagnosis: _____

Father/Other: Name: _____

(H) _____ (W) _____ (cell) _____

Allergies: _____

Emergency Contact: Name: _____

Preferred Hospital: _____

(H) _____ (W) _____ (cell) _____

Primary Care Provider: _____ **Phone:** _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

Other health care providers (specialists):

Phone numbers:

1. _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

2. _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

3. _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

4. _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

Other Consultants/Specialists (e.g. ed, mental health, soc serv) Phone numbers:

1. _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

2. _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

3. _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

4. _____

Permission to contact: YES/ NO

Parent/Guardian signature: YES/ NO

EMERGENCY PLAN

Steps to take during an asthma episode:

1. Give authorized medications as listed. Child should respond to treatment in 15-20 minutes.
2. Contact parent/guardian.
3. Call 911 if student has any of the following symptoms:
 - No improvement 15-20 minutes after initial treatment
 - Difficulty breathing with:
 - Chest and neck pulling in with breathing
 - Stooped or hunched over posture
 - Struggling or gasping to breathe
 - Trouble walking or talking
 - Stops playing and can't start activity again
 - Lips or fingernails are grey or blue

●Emergency Asthma Medications

Name	Amount	When to Use
1. _____		
2. _____		
3. _____		
4. _____		

DAILY ASTHMA MANAGEMENT PLAN

●Identify the things which start an asthma episode (Check each that applies)

- | | | |
|---|--|---|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Gardening/ leaves/ grass |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust/dust/ glue | <input type="checkbox"/> Plants: Indoor/ Outdoor |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room | <input type="checkbox"/> Painting/ Renovations |
| <input type="checkbox"/> Windy or cold air | <input type="checkbox"/> Pollens | <input type="checkbox"/> Animals _____ |
| <input type="checkbox"/> Food _____ | <input type="checkbox"/> Molds | <input type="checkbox"/> Other _____ |

Comments _____

● Control of Child Care Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the child needs to prevent an asthma episode.) _____

● **Daily Medication Plan**

Name	Amount	When to Use
1. _____		
2. _____		
3. _____		
4. _____		

COMMENTS/SPECIAL INSTRUCTIONS

Health Care Provider/ Prescriber

Date

Parent/Guardian Signature

Date

Reviewed by: _____

Director: _____

Date

Health Consultant: _____

Date

Teachers: _____

Date

Health Care Provider: _____

(If possible)

Date

Next Review Date: _____

Adapted from AAFA Student Asthma Action Card