# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HEAD START

**ASTHMA/RESPIRATORY HEALTH ACTION CARE PLAN**

**This form must be completed and signed by a Health Care Provider**

**Name** DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Classroom: \_\_\_\_\_\_\_\_

**Medical Provider** Phone Number

**Parent’s Name** Phone Number

**Are there any program areas that will need to be changed to accommodate child**? YES NO

 (Outdoor activities, field trips, nutrition, classroom environment, transportation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does child have acute/chronic asthma?  YES  NO

Or other respiratory diseases? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  YES  NO How often? \_\_\_\_\_\_\_\_\_\_

 Does child use medication for acute attacks?  YES  NO

**\*\*Important\*\***

**Should this child have medication at school in the event of an acute asthma attack?  YES  NO Does medication need to be available during bus transportation?**  ** YES  NO**

***(Medication only transported if yes is indicated)***

 **ASTHMA/RESPIRATORY Triggers** *Circle if they apply*

Colds or respiratory infections Weather changes

Strong emotions

Hard exercise/ activity Strong odors

Cigarette smoke Pollen

 Food (list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASTHMA/RESPIRATORY Signs/Symptoms**

* Consistent cough/wheezing (dry, tight and non-productive)
* Flaring nostrils/ open mouth (panting)
* Frequent throat clearing/ grunting
* Shortness of breath/ breathing faster
* Trouble playing, eating, drinking, talking
* Slouching/ bending over to help him/her breathe
* Restlessness or agitation (child may appear frightened or worried)
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment of an ASTHMA/RESPIRATORY attack –** *Circle the ones that help the client/ can be used at school*

1. Remain calm and reassure the person
2. Observe the person closely and do not leave them alone
3. Encourage the person to breathe slowly
4. If the person has medication, give it according to instructions
5. Continually assess the person and begin rescue breathing if necessary
6. If at school, call the parent immediately

# CALL 911:

If breathing becomes rapid (child = >50 breaths/minute, adult= >30 breaths/minute)

If the person loses consciousness

If the person becomes cyanotic (blue), check the mouth, lips and fingernails for color

**Other instructions for this child’s care \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Parent/guardian signature**: Date

**Provider signature & Title:** Date