East Hartford YMCA
ASTHMA SPECIAL CARE PLAN

Child's Name: ______________________ **Date of Birth:** _____________

Typical signs and symptoms of the child's asthma episodes (check all that apply):

__fatigue
__flaring nostrils, mouth opens (panting)
__dark circles under eyes
__gray or blue lips or finger nails
__persistent cough
___difficulty playing, eating, drinking, talking
__wheezing
__restlessness/agitation
__red face, pale or swollen
__grunting
__sucking in chest/neck
__complaint chest pains/tightness
__breathing faster
__other:____________________

Steps to take during an asthma episode:

1. Give medications as listed below*.

   Special Instructions: ____
   ____

   Emergency Asthma Medications

Name of Medication	Amount	When to Use
1.		
2.		
3.		

**Authorization for the Administration of Medication form must be on file for each medication.*

2. Check for decreased symptoms.
3. Contact parent/guardian immediately if emergency medication is required.
4. Call 911 if:
   a. The child has not improved in 15 min. after treatment and family can not be reached.
   b. After receiving a treatment for wheezing, the child:

   - Is working hard to breathe or grunting
   - Is breathing fast at rest(>50/min)
   - Has trouble walking or talking
   - Have nostrils open wider than usual
   - Has sucking in of the skin (chest/neck) with breathing
   - Won't play
   - Has gray or blue lips/finger nails
   - Cries more softly and briefly
   - Is hunched over to breathe
   - Is extremely agitated or sleepy

5. If no medication is needed while the child is attending the program, please have the doctor initial below.

_________**No medication required while attending child care program**
**Doctors initials are required*

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FOR YOUTH DEVELOPMENT
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

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Child's Name: ______________________ Date of Birth: ______________

Physician's name: ____

Physician's signature: ____

Phone number: (____) - ____________ Date: ____________

Parent's name: _______________ Parent's signature: ______________

Staff Signatures:

__________Authorization for the Administration of Medication form and medication on site

I have read and understand the attached Asthma Care Plan for: ______________
(Child's name)

Teacher's Name: ________________Teacher's Signature: __________________

Teacher's Name: ________________Teacher's Signature: __________________

Teacher's Name: ________________Teacher's Signature: __________________

Teacher's Name: ________________Teacher's Signature: __________________

Teacher's Name: ________________Teacher's Signature: __________________

Teacher's Name: ________________Teacher's Signature: __________________

Child Care Director: ____________________Date: ________________________

Child's doctor and Child Care facility should keep a current copy of this form in child's record.