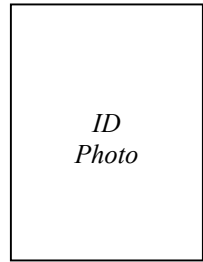




**CHILD CARE ASTHMA/ALLERGY
ACTION CARD**



Name: _____

Grade: _____ DOB: _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Parent/Guardian Name: _____

Address: _____

Phone (H): _____ (W): _____

Other Contact Information: _____

Emergency Phone Contact #1 _____
Name

Relationship _____ Phone _____

Emergency Phone Contact #2 _____
Name

Relationship _____ Phone _____

Physician Child Sees for Asthma/Allergies: _____

Phone: _____

Other Physician: _____

Phone: _____

DAILY ASTHMA/ALLERGY MANAGEMENT PLAN

- **Identify the things that start an asthma/allergy episode**

(Check each that applies to the child)

— Animals — Bee/Insect Sting — Chalk Dust — Change in Temperature

— Dust Mites — Exercise — Latex — Molds

— Pollens — Respiratory Infections — Smoke — Strong Odors

— Food: _____

— Other: _____

Comments: _____

- **Peak Flow Monitoring** (for children over 4 years old)

Personal Best Peak Flow reading: _____

Monitoring Times: _____

- **Control of Child Care Environment** (List any environmental control measures, pre-medications, and/or dietary restrictions that the child needs to prevent an asthma/allergy episode.) _____

- **Daily Medication Plan for Asthma/Allergy**

	Name	Amount	When to Use
1			
2			
3			
4			

OUTSIDE ACTIVITY AND FIELD TRIPS The following medications must accompany child when participating in outside activity and field trips:

	Name	Amount	When to Use
1			
2			
3			

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as _____

or has a peak flow reading at or below _____

• Steps to take during an asthma episode:

1. Check peak flow reading (if child uses a peak flow meter).
2. Give medications as listed below.
3. Check for decreased symptoms and/or increased peak flow reading.
4. Allow child to stay at child care setting if: _____

5. Contact parent/guardian
6. Seek emergency medical care if the child has any one of the following:

→ No improvement minutes after initial treatment with medication.
 → Peak flow at or below _____.
 → Hard time breathing with:
 ➢ Chest and neck pulled in with breathing.
 ➢ Child hunched over.
 ➢ Child struggling to breathe.
 → Trouble walking or talking.
 → Stops playing and cannot start activity again.
 → Lips or fingernails are gray or blue.

***IF THIS
HAPPENS, GET
EMERGENCY
HELP NOW!***

→ **Mouth/Throat:** itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
 → **Skin:** hives; itchy rash; swelling
 → **Gut:** nausea; abdominal cramps; vomiting; diarrhea
 → **Lung*:** shortness of breath; coughing; wheezing
 → **Heart:** pulse is hard to detect; "passing out"
 *If child has asthma, asthma symptoms may also need to be treated.

• Emergency Asthma Medications:

	Name	Amount	When to Use
1			
2			
3			
4			

• Special Instructions:

ALLERGY EMERGENCY PLAN

• **Child is allergic to:** _____

• Steps to take during an allergy episode:

1. If the following symptoms occur, give the medications listed below.
2. Contact Emergency help and request epinephrine.
3. Contact the child's parent/guardian.

• Symptoms of an allergic reaction include:

(Physician, please circle those that apply)

• Emergency Allergy Medications:

	Name	Amount	When to Use
1			
2			
3			
4			

• Special Instructions:

Physician's Signature

Date

Parent/Guardian's Signature

Date

Child Care Provider's Signature

Date