CHILD CARE ASTHMA/ALLERGY ACTION CARD

ID Photo

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			

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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!

- **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)

→**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 Allergy Medications:**

	Name	Amount	When to Use
1			
2			
3			
4			

- **Special Instructions:**

____

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Physician's Signature	**Date**	**Parent/Guardian's Signature**	**Date**	**Child Care Provider's Signature**	**Date**