Asthma: cover page and sample action plan

Canadian Paediatric Society

Fill out and refer to this document for children who have asthma.

For: _____ **[child's name]**

CHILD'S PHOTO

Date developed: _____

Review date(s): _____

Note: Review this information with the parents every 6 months or whenever their child's treatment changes.

Child's birth date: _____

Child's weight: _____

Designated staff member (if applicable):

_____

Contact information

Mother/guardian: _____

Tel: Home _____ Work _____ Cell _____

Father/guardian: _____

Tel: Home _____ Work _____ Cell _____

Child lives with: _____

Child's doctor's name: _____ Tel: _____

Allergy specialist's name (if applicable): _____ Tel: _____

Alternate emergency contact (if parents are unavailable): _____

Relationship to child: _____

Tel: Home _____ Work _____ Cell _____

Notify parents/guardians or emergency contact in the following situations: _____

_____

Note any other conditions that may affect the treatment of this child: _____

_____

Content from Well Beings: A Guide to Health in Child Care. For more information, visit www.cps.ca.

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Asthma episodes

Known triggers for this child's asthma (circle all that apply):

- cold viruses
- smoke and smoking
- allergies (e.g., dust, pollen, mould, feathers, animal dander, or other _____)
- odours (e.g., paint fumes, aerosol sprays, cleaning materials, chemicals, perfumes, or other [e.g., foods] _____)
- strenuous exercise
- weather conditions (e.g., cold air, weather changes, windy or rainy days)
- vigorous crying or laughing

Other (please specify): _____

Name of irritant/allergy (e.g., perfumes in cosmetics, soap, aftershave)	Reaction (e.g., wheezing, coughing)

Is there a time of year when this child seems to have more asthma episodes?

❑ Yes ❑ No

If so, when? _____

Typical signs or symptoms of this child's asthma episodes (circle all that apply):

- coughing
- difficulty breathing
- a wheezing or whistling sound when breathing out
- chest tightness

Other (please describe): _____

Does this child tend to develop a very severe episode very quickly?

❑ Yes ❑ No

Additional comments concerning episodes: _____

_____

_____

_____

Does this child carry an Allerject or EpiPen?

❑ Yes ❑ No

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Asthma management

Complete the following schedule

Medications for routine and emergency treatment of asthma for: Child's name			
Time	Medication name and dosage	Method (e.g., metered-dose inhaler and spacer [AeroChamber])	How much
Morning			
Noon			
Afternoon			
Night			
Possible side effects, if any:			
Describe all other medications or products to be used when needed (e.g., ointments, antihistamines, sunscreens, etc.)	Name (e.g., salbutamol)	Reason used (e.g., to relieve symptoms)	How often (e.g., only as needed)
Parent's permission to follow this medication plan	Date:	Signature:	

Reminders

1. Administer medication as specified and record on the child's *Medication consent form and record sheet*.
2. If the episode seems unusually severe or persistent, **call 911** (or emergency services where 911 service is unavailable).
3. If the attack persists but is not severe, advise the parents to pick up their child early and see a doctor.

Questions or concerns to be discussed with the child's doctor:

_____

_____

_____

_____

_____

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