Bright Horizons
Asthma Action Plan

Child's Name: ________________________________ Date of Birth: _______________
Facility Name: ________________________________ Date: ______________________

The following information should be completed by the child's medical provider and parent/guardian.

Severity: ☐ Mild ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Check all triggers: (completed by child's medical provider)

☐ Smoke (cigarette) ☐ Colds/flu ☐ Dust mites ☐ Exercise:__________________ __________
☐ Sudden temperature changes ☐ Ozone Alert ☐ Pet dander ☐ Strong Odors_____________________
☐ Wood smoke ☐ Cut flowers, grass or pollen ☐ Mold ☐ Food: _________________
☐ Cleaning Products: ____
☐ Others: ____

Suggested classroom strategies to support this child's needs

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____
____

Specific Medical Information:

Medication to be administered: ☐ Yes ☐ No If yes, medication to be administered: ____________________
____

☐ Authorization for Administration of Medication Form: Completed by the Medical Provider and Parent/Guardian on file (Including type of medication, method of administration, time schedule, potential side effects)

Location of medication to be administered: ____

Additional medication information: ____
____

Potential consequences to child if treatment is not administered: _________________________________
____
____

Special Staff Training Needs:

Type (be specific): ____
____
____
____

Additional Emergency Procedures/Instructions:

____
____
____
____

Notify parent/guardian: (name) ____Phone #: _______________

Notify parent/guardian: (name) ____Phone #: _______________

Emergency Contact: (name) ____ Phone #: _______________

GO (Green Zone)

The child is able to do all of these:	What to do:	Medication:
• Breathing is regular • No cough or wheeze • Can engage in active play	• Allow current activity	• "As needed medication" not needed at this time • Regular medication should be given as ordered

CAUTION (Yellow Zone)

The child has any of the following:	What to do:	Medication
• Early signs of a cold (runny nose, sneezing) • Exposure to a known trigger • Cough • Mild Wheeze • Chest tightness	• Cease current activity • If the child is outdoors bring inside • Observe breathing before and after the treatment (15 minutes)	• Administer the "As needed medication" (see the medication administration form and follow directions for use) • Monitor breathing status if no improvement follow the steps for the DANGER (Red Zone)

DANGER (Red Zone)

The child's asthma is worse and any of the symptoms are seen:	What to do:	Medication:
• The medications are not helping within 15-20 minutes of being given. • Breathing is becoming hard and fast • Nose (nostrils) open wide • Ribs are showing • Lips, fingernails or mouth area are blue or blue gray in color • Trouble walking or talking	• Activate EMS (emergency medical services) • Stay with the child—Stay calm • Ancillary staff notify the parent/guardian • Accompany the child to ER • Complete an incidence form within 24 hours	• Medication available has already been given with no relief • Notify EMS staff regarding the type of medication and the time it was given.

Signatures:

Parent/Guardian: ____ Date: ____________________

Medical Provider: ____Date: ____________________

Director/Principal: ____Date: ____________________

(This plan contains information from California Childcare Health Program (CCHP): http://www.ucsfchildcarehealth.org and http://foodallergy.org/)

This plan must be updated annually or whenever the child's medication or health status changes.