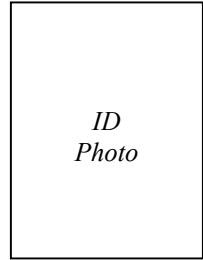




**CHILD CARE ASTHMA/ALLERGY  
ACTION CARD**



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: \_\_\_\_\_  
 Address/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