ASTHMA CARE PLAN

This form must be completed by a physician and returned to CAHS
Prior to a child participating in the classroom

Child:____Date of Birth: _________________________

Parent's Name: _________________________ Address:____

Head Start Center Child Attends:____

_______ Child has a history of Asthma or RAD, but is currently not being treated routinely. **Child will need emergency medication at school.**

______ Child diagnosed with Asthma or RAD and **needs** emergency **medication at school**.

_______ Child is not being treated for Asthma or RAD at this time and **does not** need medication at school.

This child's Asthma or RAD may be triggered by: ____

Activities for which this child has needed special attention in the past: ______________________________

Activity restrictions: ____

Any other information you feel would be beneficial: ____

Medication

1. Medication: __________________________________ Medication: _________________________________

Dose: ____ Dose: _______________________________________

Time: ____ Time: _______________________________________

Routine or Emergency: _________________________ Routine or Emergency: ________________________

Physician's Name:_______________________________ Signature ___________________________________
(Please Print)

Address: _______________________________________ Phone Number: _____________________________

Date: ______/_____ /______
Thank-you, C.A.H.S. Health Staff

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