





INDIVIDUAL HEALTH CARE PLAN (IHCP) ASTHMA (2)

Name: _____		Birthdate: yyyy/mmm/dd _____		Photo
School/Community Program: _____				
Grade: _____	MHSC: _____	PHIN: _____		
MediAlert™ bracelet worn? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the child ride the bus? <input type="checkbox"/> Yes Bus No. _____ <input type="checkbox"/> No		
Parent/Guardian Name: _____		Home Phone No.: _____	Daytime Phone No.: _____	Cell Phone No.: _____
Parent/Guardian Name: _____		Home Phone No.: _____	Daytime Phone No.: _____	Cell Phone No.: _____
Alternate emergency contact: _____		Home Phone No.: _____	Phone No.: _____	Cell Phone No.: _____
Allergist: _____			Phone No.: _____	
Pediatrician/Family Doctor: _____			Phone No.: _____	
TRIGGERS: List items that most commonly trigger your child's asthma. _____ _____				
RELIEVER MEDICATION (or bronchodilator) provides fast temporary relief from asthma symptoms. It is recommended that reliever medication is carried with the child so it is available if asthma episode occurs.				
What reliever medication has been prescribed for your child? (CHECK ONE)		<input type="checkbox"/> Salbutamol (e.g. Ventolin®, Novo-Salmol®) <input type="checkbox"/> Budesonide (e.g. Symbicort®) <input type="checkbox"/> Other: _____		
How many puffs of reliever medication are prescribed for an asthma episode? (CHECK ONE)		<input type="checkbox"/> 1 puff <input type="checkbox"/> 1 or 2 puffs <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____		
Where does your child carry his/her reliever medication?		<input type="checkbox"/> fanny pack <input type="checkbox"/> purse <input type="checkbox"/> backpack <input type="checkbox"/> other _____		
Does your child need help when using reliever medication?		<input type="checkbox"/> Yes What kind of help? _____ <input type="checkbox"/> No		
CIRCLE the type of medication device your child uses for <u>reliever medication</u>:				
				_____
Metered dose inhaler (MDI)	MDI with Aerochamber®	MDI with Aerochamber® mask	Turbuhaler®	other


The Individual Health Care Plan and emergency medication should accompany the child on excursions outside the facility.

Name: _____

Birthdate: _____

PHIN: _____

STANDARD HEALTH CARE PLAN (SHCP) ASTHMA

IF YOU SEE THIS: 	DO THIS:
<p><u>Signs of an asthma episode:</u></p> <ul style="list-style-type: none">▪ Coughing▪ Wheezing▪ Chest tightness▪ Shortness of breath▪ Increase in rate of breathing	<ol style="list-style-type: none">1. Remove the child from triggers of asthma (e.g. exercise, cold air, smoke).2. Have child sit down.3. Ensure the child takes reliever medication (blue cap).4. Encourage slow deep breathing.5. Monitor child for improvement.
<p><u>Emergency Situations:</u></p> <ul style="list-style-type: none">▪ Reliever medication has been given and there is no improvement of asthma symptoms in 5 minutes▪ Greyish/bluish color in lips and nail beds▪ Inability to speak in full sentences▪ Heaving of chest or chest sucking inward▪ Shoulders held high, tight neck muscles▪ Cannot stop coughing▪ Difficulty walking <p>If asthma symptoms are severe, the child may NOT be wheezing as there is not enough air moving in the lungs to generate a wheeze.</p>	<ol style="list-style-type: none">1. Activate 911/EMS.2. Give reliever medication every 5 minutes.3. Notify parent/guardian.4. Stay with child until EMS personnel arrives
<p><u>Signs that asthma is not controlled</u></p> <p>If staff become aware of any of the following situations, they should inform the child's parent/guardian.</p> <ul style="list-style-type: none">▪ Asthma symptoms prevent child from performing normal activities.▪ Child appears to be experiencing more frequent coughing, shortness of breath or wheezing.▪ Child is using reliever medication more than 3 times per week to relieve asthma symptoms. An exception to this includes the use of reliever medication before exercise to prevent exercise induced asthma symptoms, which then may be used up to once a day.	

I have reviewed the above plan for my child and provide consent to this plan on behalf of my child.

Parent/guardian signature: _____ **Date:** _____ yyyy/mmm/dd

I have reviewed the above plan to ensure it provides the community program with required information.

Nurse signature: _____ **Date:** _____ yyyy/mmm/dd

I have received the above plan and have notified appropriate staff.

Program Designate signature: _____ **Date:** _____ yyyy/mmm/dd

Instruction sheet for medication device attached

FOR OFFICE USE ONLY:
