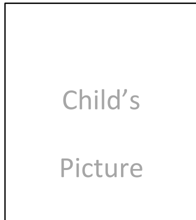
STARFISH FAMILY SERVICES



ASTHMA ACTION PLAN

Please complete entire form

Child's Name: ___________________________________Date of Birth _________________

Center: ___________________Teacher/Home Visitor: ______________________________

Parent/Guardian's Name: _______________________________________ Phone: ______________________

Asthma Triggers: O Colds O Exercise O Weather O Smoke/strong odors O Dust O Animals O Mold
O Food ______________________ O Other _______________________________________

***List any environmental control methods and/or dietary restrictions that the child needs to prevent an asthma episode*:** ____

Asthma Medication to be given in the classroom – must have physician fill out the Physician/ Parent Medication Authorization Form for school.
Note: Parents are responsible for administering medications for home-based children at socializations and other Head Start activities.

List Asthma Medications: __________________________________ ____________________________________
__________________________________ ____________________________________

Warning signs of an asthma episode:	*Circle/Check all that apply for Asthma:*
cough (continuous), cannot work/play, stooped body posture, chest/neck pulled in with breathing, wheeze, lips or fingernails are blue/gray.	_____ **1. Call 911** _____ **2. Call Parent** _____ **3. Call Child's Physician** _____ **4. Do CPR if needed** _____ **5. Stay with Child at all times**

Special Instructions: ____
____

Physician's Signature
____*Date:* ________________________

Physician Name: ____ *Phone:* ________________________
Please Print

Head Start Use Only

I agree with the above classroom Asthma Action Plan.

____
Parent/Guardian Signature Date

____
Teacher/Home Visitor Date

____
Site Leader Date

____
Health Manager or Specialist Signature Date

Entered and attached in ChildPlus: _________________ 2020