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: ________________________________

Phone: ________________________________________________________________

Other Physician: ________________________________________________________

Phone: ________________________________________________________________

** Daily Medication Plan for Asthma/Allergy

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** Control of Child Care Environment** (List any environmental control measures, premedications, and/or dietary restrictions that the child needs to prevent an asthma/allergy episode.)

** OUTSIDE ACTIVITY AND FIELD TRIPS** The following medications must accompany child when participating in outside activity and field trips:

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Rev. 5/01
**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.

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**ALLERGY EMERGENCY PLAN**

- Child is allergic to:

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**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)

- 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.

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**Emergency Asthma Medications:**

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**Emergency Allergy Medications:**

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**Special Instructions:**

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Physician’s Signature  Date  Parent/Guardian’s Signature  Date  Child Care Provider’s Signature  Date