Complete and submit this form only if it applies to your child.

# Asthma Emergency Action Plan for _____ year

**Child's Name:** _____ **Age:**_____

**Centre Name:** _____ **Centre Address:**_____

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian: _____

Phone (home/cell): _____ Phone (work): _____

Emergency Contact: _____

Phone (home): _____ Phone (work): _____

Health Care Provider: _____ Office Phone: _____

**Picture ID**

## CHILD'S ASTHMA TRIGGERS ARE:

☐ change in temperature ☐ colds, infection ☐ dust, mites ☐ emotion (e.g. upset) ☐ mould ☐ physical activity ☐ pollen

☐ animals (list): _____

☐ foods (list): _____

☐ strong smells (list): _____

☐ Other: _____

## CHILD'S ASTHMA SYMPTOMS ARE USUALLY:

☐ appears anxious
☐ coughing
☐ difficulty talking
☐ fast/shallow breathing
☐ pale
☐ hunched over
☐ short of breath
☐ wheezing
☐ in-drawing/tracheal tug
☐ other (list below):
☐
☐

## CHILD'S EMERGENCY TREATMENT:

☐ Medication is stored:

☐ Medication expiry date:

☐ Field Trip Plans:

- **GIVE** _____

(Name of medication)

- **Follow Instructions:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

- **If unsure, child is worse, or not getting better CALL 911**
- **CALL PARENTS**

*It is the parent's responsibility to notify the facility of any change in the child's condition.*

**Sign below if you agree with above information & plan:**

_____ _____
Parent/Guardian Date

_____ _____
Child Care Staff Date