

Child Care Training and Resource Kit

Asthma in the Classroom

Handouts

ASTHMA INFORMATION FORM

Today's Date: _____

Child's name: _____ Center/School _____

Parents/Guardians _____

Telephone: Home _____ Work _____ Other _____

Name of Child's Doctor/Nurse Practitioner for Asthma? _____

Address (if known) _____ Phone - _____

Do we have your permission to call your child's health care provider for more information about your child's asthma? Yes _____ No _____

Please tell us the following information to the best of your ability.

1. When was your child diagnosed with asthma? _____ (who)
2. How many days would you estimate that your child was sick last year due to asthma? _____
3. How many times in the past year has your child been:
Hospitalized overnight due to asthma? None _____ once _____ 2-4 times _____ more than 4 times _____
Treated in the Emergency Room due to asthma? None _____ once _____ 2-4 times _____ more than 4 times _____
Treated in a doctor's office for an asthma attack? None _____ once _____ 2-4 times _____ more than 4 times _____
Treated with a steroid medicine called Prednisone? None _____ once _____ 2-4 times _____ more than 4 times _____
4. When was the last time you saw your child's health care provider for asthma? _____

1. What **triggers** your child's asthma? Check all that apply.

colds or respiratory infections _____	strong odors _____	hard exercise/activity _____
weather changes _____	cold air _____	cigarette smoke _____
strong emotions _____	animals _____	pollen _____
fireplace or wood stove smoke _____	foods (list) _____	

allergies (please list) _____

allergies to medications (please list) _____ Others _____

2. What are your child's early warning signs of an asthma attack? Check all that apply.

Cough _____	cranky _____	drop in peak flow numbers _____
runny nose _____	eating less _____	less running around & playing _____
wheezing _____	itchy, watery eyes _____	working harder to breathe _____
throwing up _____	trouble sleeping _____	

3. If your child is monitored with a peak flow meter, what is his/her best peak flow rate? _____

4. Are there any special considerations that your child may need while at the center/school related to his/her asthma?

Please list all medications your child takes for asthma. Be sure to include all medicines taken every day as well as the medicines taken every once in a while. We also need to know how the medicine is taken; nebulizer, puffer, or MDI with or without a spacer or holding chamber, or liquids or pills.

Medicine taken everyday	Amount	How taken	What times
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medicine taken only when Needed	Amount	How taken	What times
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. Have you noticed any side effects when your child takes his/her medications?

2. If your child has a severe asthma attack requiring we call 911 or emergency services, what is your choice of hospital or Emergency Room for treatment? *(Note: Hospital choice may not always be an option at the time of the emergency).*

Parent/Guardian signature

Date

(A signed form for medication must be provided if medications are required during school hours.)

Classroom Health Plan

Child's Name: _____ Birth Date: _____

Health Condition(s):

What can we do to prepare the classroom environment for your child?

Treatments, Tests or medications your child will need during the school day:

Time:	Instructions:
Time:	Instructions:
Time:	Instructions:

Parent Requests:

If We See This:

Do This:

Food Allergies:

List Each Food Separately

List Appropriate Food Substitutes

Describe How Child Reacts to the Food

		Severe reaction: ____yes ____no
		Severe reaction: ____yes ____no
		Severe reaction: ____yes ____no

Emergency Plan for Severe Allergic Reaction:

If the child develops signs of severe allergic reaction such as:

hives, itching, flushed face or skin, swelling of face, lips, mouth, vomiting, diarrhea, feeling of impending doom and/or difficulty breathing

The child care center will implement the following emergency plan

_____Administer prescribed epinephrine (EpiPen) immediately

and/or

_____Administer other prescribed medication:

_____ medication and dosage

_____ medication and dosage

- 1) Call 911 2) Call parent 3) Call child's physician 4) Stay with child at all times**

Medication

We will need more information on medications that the child takes on a regular schedule, at school as well as at home. *For* medications taken at home, we ask for a 3 day supply to be kept with our disaster kit, in the case of an earthquake or other disaster. Please fill out all of the categories:

Medication Name	Reason:	Dose:	How Given (<i>by mouth, on skin, nebulizer, etc.</i>):	Schedule:	Possible Side Effects

I agree with the above classroom health plan:

Parent Signature: _____ Date: _____

Health Provider's Signature: _____ Date: _____

(Health provider's signature required for food allergies and for medications that require health provider's signature, per Department of Health Guidelines.)

Teacher Signature: _____ Date: _____

Assistant Teacher Signature: _____ Date: _____

Director/Site Manager/Health Coordinator Signature: _____

Documentation of STAFF TRAINING on Classroom Health Plan

Staff Name	Topic	Trainer	Date

1 **Asthma In the Classroom**

2 **Epidemiology**

- Most common disease of childhood
- 10% have asthma
- Males > females
- Family history common

3 **Prevalence**

- Rapid rise all over the world
- 1980—6.7 million people with asthma
- 1998—17.3 million people with asthma
- Greatest increase: low income neighborhoods

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7 **Asthma Triggers**

- Respiratory or sinus infections
- Allergens
- Cold air and weather changes
- Emotional distress
- Known irritants and occupational chemicals
- Exercise

8 **Signs and Symptoms**

- Cough
- Wheezing
- Shortness of breath
- Increased work of breathing
- Anxious
- Pale to cyanotic

9 **Associated Symptoms**

- Poor appetite
- Irritability
- Poor sleep
- Restlessness
- Reduced tolerance for activity
- Vomiting

10 **What You Need to Know:**

- How long has child had asthma?
- How many times hospitalized or treated?
- Triggers?
- Early warning signs?
- Medications?
- Response to treatment?