This page to be completed by:
Program Staff and Parent or Guardian

Public Health
Seattle & King County

Asthma Care Plan Request Form

Child's Name: _____

Child's Date of Birth: _____

Early Learning or Child Care Program Director: **Abby Maclean**

Early Learning or Child Care Program: **Bellevue Children's Academy**
EARLY CHILDHOOD EDUCATION

Mailing Address: Bellevue Children's Academy, North Campus - Satellite 1, 14719 NE 29th Pl., Bellevue, WA 98007
Bellevue Children's Academy, North Campus - Satellite 2, 14673 NE 29th Pl., Bellevue, WA 98007

Phone Number: 425-649-0791 - Satellite 1 (Opt. 3); Satellite 2 (Opt. 4)

E-mail: satellite@bcacademy.com

Healthcare Provider: The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans. **Please complete pages 2-5**. These are forms that require a healthcare provider's instructions and signature.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): _____

Parent or Guardian Signature: _____

Date: _____

Parent or Guardian Phone Number: _____

My Asthma Plan

Patient Name: _____

Medical Record #: _____

Provider's Name: _____

DOB: _____

Provider's Phone #: _____ Completed by: _____ Date: _____

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day EVERYDAY!	❑ Gargle or rinse mouth after use ❑ Always use a spacer with your inhaler
		_____ times per day EVERYDAY!	❑ Gargle or rinse mouth after use ❑ Always use a spacer with your inhaler
Quick-Relief Medicines	**How Much to Take**	**How Often**	**Other Instructions**
❑ Albuterol (ProAir, Ventolin, Proventil) ❑ Levalbuterol (Xopenex) ❑ Corticosteroid/Formoterol (Symbicort, Breyna, Dulera, Other: _____)	❑ 1 puff ❑ 2 puffs ❑ 4 puffs ❑ 1 nebulizer treatment	Take ONLY as needed (see below — starting in Yellow Zone or before excercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.

Special instructions when I am ***doing well,*** ***getting worse,*** ***having a medical alert.***

GREEN ZONE

Doing *well.*

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

Peak Flow (for ages 5 and up):
is _____ or more.(80% or more of personal best)
Personal Best Peak Flow (for ages 5 and up): _____

PREVENT asthma symptoms every day:

❑ Take my controller medicines (above) every day.

❑ Before exercise, take ___ puff(s) of _____.

❑ Avoid things that make my asthma worse.
(See pages 3 and 4)

YELLOW ZONE

Getting *worse.*

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

Peak Flow (for ages 5 and up):
_____ to _____ (50 to 79% of personal best)

CAUTION. Continue taking every day controller medicines, AND:

❑ Take __ puffs or one nebulizer treatment of quick relief medicine. If I am not back in the ***Green Zone*** within 20-30 minutes take __ more puffs or nebulizer treatments. If I am not back in the ***Green Zone*** within one hour, then I should:

❑ Increase _____

❑ Add _____

❑ Call _____

❑ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in _____days.

RED ZONE

Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

Peak Flow (for ages 5 and up):
less than _____ (50% of personal best)

MEDICAL ALERT! Get help!

❑ Take quick relief medicine: _____ puffs every _____ minutes and get help immediately.

❑ Take _____

❑ Call _____

Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or breathing is hard, fast, or labored and/or child doesn't respond normally.

Health Care Provider: My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ❑ Yes ❑ No Self administer asthma medications: ❑ Yes ❑ No
(This authorization is for a maximum of one year from signature date.)

_____ _____

Healthcare Provider Signature Date

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Seattle & King County

3-Day Supply of Medication Authorization Form

This form is for any life-sustaining asthma control medication that the child usually takes when not in care.

Healthcare Provider and Parent or Guardian: In the event the child needs to remain at the program past usual hours, a 3-day supply of asthma control medication(s) must be kept at the program. A new authorization form should be completed if there are changes to the medication or child's health condition.

Program Staff: This life-sustaining medication will only be given if the child needs to remain at the program past usual hours. Each asthma control medication requires its own completed authorization form. Never give expired medication. Expired medication must be replaced, and the updated expiration date must be added to this form.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Reason for medication: _____

Possible side effects of medication: _____

Medication expiration date: _____

When to give medication (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication)**:** _____

How much medication to give (must include dose of medication)**:** _____

How long to give medication (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year)**:** _____

How to give the medication (for example: by mouth [oral], on skin [topical], injection, etc.)**:** _____

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3-Day Supply of Medication Authorization Form (Continued)

Medication requires special storage: ☐ Yes ☐ No

If yes, specify (for example: refrigerate; keep away from light; etc.)**:**_____

Additional instructions: _____

Parent or Guardian: By signing below, I give the program permission to give this medication to my child as described on this Authorization Form.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

Healthcare Provider: By signing below, I acknowledge that this child requires a 3-day supply of asthma control medication to be stored at the child's program**. It will only be given in the event the child needs to remain at the program past usual hours.**

Healthcare Provider Name (Printed): _____

Healthcare Provider Signature: _____

Healthcare Provider Phone Number: _____

Date: _____

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Seattle & King County

Additional Requirements for Care Plans

Child's name: _____

Program Staff and Parent or Guardian: The WAC requires that all care plans include the potential side effects and expiration date of medications. If this is not included in the care plan, write them in the table below. **You may find this information on the medication packaging or label.**

Medication Name	Expiration Date	Potential Side Effects

Program Staff and Parent or Guardian: The WAC requires a parent**,** guardian, or appointed designee to provide training to program staff about medication administration or special medical procedures listed in the child's care plan. **Use the space below to document this training.**

Employee Training Record				
Date of Training	**Employee Name (Printed)**	**Employee Signature**	**Trainer Name (Printed)**	**Trainer Signature**

Program Staff and Parent or Guardian: The WAC requires written consent from a child's parent or guardian before a program can administer any medications or follow a care plan that is completed by a healthcare provider. **Please have the parent or guardian sign below.**

By signing below, I give the program permission to follow this care plan as ordered by the healthcare provider.

Parent or Guardian Name (Printed)**:** _____

Parent or Guardian Signature: _____

Date: _____

This page to be completed by:
Parent or Guardian

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Seattle & King County

Emergency Contact Information

Child's name: _____

Parent or Guardian: If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

Emergency Contact #1

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #2

Name: _____

Relationship to Child: _____

Phone Number: _____

Emergency Contact #3

Name: _____

Relationship to Child: _____

Phone Number: _____

This page to be completed by:
Program Staff

Public Health
Seattle & King County

Medication Log

Program Staff: Please print a copy of this Medication Log for each medication in the care plan.

Child's name: _____

Child's date of birth: _____

Name of medication: _____

Date	Time	Dose	Person Giving Medication (*Initials)	Reason Medication Was Not Given	Observed Side Effects

Initials*	Printed Name and Signature of Person Giving Medications