OCFS-LDSS-7006

Asthma Action Plan

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Working in collaboration with the child's parent/guardian and child's health care provider, the following health care plan was developed to meet the individual needs of:

Child's Name:	Child's date of birth:
Name of the child's health care provider:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Has asthma which maybe induced by:

◯ **Check if medication should be administered _____ minutes prior to gym or exercise**

Early warning signs may include: behavior changes such as nervousness, headache, fatigue, coughing, stuffy or runny nose, watery eyes, itchy throat or chin.

Other:____

- If early warning signs are observed, remove the child from any known triggers and allow them to rest. If needed offer them an alternative activity.

Symptoms of an asthma episode may include: acting agitated or scared, breathing rapidly or differently, wheezing, can't stop coughing, expresses trouble breathing, chest tightness, sitting with shoulders hunched over, unusually pale skin

Other: ____

If the following symptoms are observed (specified on medication consent):

- Administer (Medication name and strength)____________________(Dose)__________ as prescribed by the doctor and following the administration instructions on the pharmacy package insert.
- Notify parents of symptoms and medication administration.
- Offer the child a period of rest.
- Continue to monitor to see that symptoms improve.
- If symptoms do not improve after 15 minutes or they worsen notify the parent and call 911 immediately.
- Worsening symptoms may include: refusing to participate, hard and fast breathing, nostrils wiser than usual, gray or blue fingernails, difficulty talking or walking, child is hunched over, skin appears sunk in on face, chest or neck, extreme agitation or fatigue.

Identify the program staff who will provide care to this child with special health care needs:

Name	Credentials or Professional License Information*

This is a double-sided form

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Continued

Describe any additional training, procedures or competencies the staff identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

Date ___________ Parent provided training on the specific needs of ___________ pertaining to the child's asthma condition and the individual health care plan.
The following staff were present:

If staff that are not MAT trained may administer the medication:
Date___________ Training was provided by
(Circle one) The parent, an authorized health care provider, or the health care consultant

Name of person providing training: ____
On the proper administration of the medication to the following staff:

Signature of Authorized Program Representative:

I understand that it is my responsibility to follow the above plan and all health and infection control day care regulations related to the modality of care I provide. This plan was developed in close collaboration with the child's parent and the child's health care provider. *I understand that it is my responsibility to see that those staff identified to provide all treatments and administer medication to the child listed in the specialized health care plan have a valid MAT certificate, CPR and first aid certifications or have a license that exempts them from training; and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

Provider/Facility Name:	Facility ID Number:	Facility Telephone Number:
Authorized child care provider's name (please print):		Date:
Authorized child care provider's signature:		

Signature of Parent or Guardian:

	Date: