

ASTHMA POLICY

1. Every child who has asthma shall have an asthma special care plan from his/her health care provider. If a child does not require medication for his/her asthma, this must be stated on the special care plan.
2. The plan shall include the following:
 - Child's name, date of birth parent's or guardian's name, emergency phone numbers, health care provider's name and phone number, including emergency phone number, and asthma care specialist's name, if any, including phone number and emergency phone number.
 - Name of medication for routine and emergency care.
 - Amount of medications and how to administer, for routine and emergency care.
 - How soon treatment should work.
 - Expected benefit for the child.
 - Possible side effects.
 - Known triggers for this child's asthma.
 - Activities that are known to trigger a need for special attention for this child.
 - Information regarding use of flow meter, and frequency of urgency care needed for this child.
 - Typical signs and symptoms of this child's asthma episodes.
 - Situations that require emergency help.
 - Dated signature of Dr.
 - Dated signature of parent.
3. Staff will receive training from the child's parents in the use of the child's special equipment and inhaled medication. In addition, staff will receive additional training when updating their pediatric first aid certificate. This training shall include the following:
 - *Preventing exposure to triggers
 - *Recognizing symptoms
 - *Use of nebulizer equipment and inhalers
 - *How to clean equipment
 - *Storage of inhaled medication
 - *What to do in an emergency
 - *How to identify side effects of medication
 - *When to notify parents
4. A consent form must be on file at the child's facility. A separate form must be filled out for each person who administers inhaled medication.

CENTER ASTHMA PLAN

1. The Asthma Policy is discussed with the parents/guardians.
2. A Nebulizer Care Consent/Verification is filled out for each staff person, who administers medication to that child.
3. The parents/guardians train the staff on how to administer inhaled medication.
4. The parents/guardians arrange for the health care provider to fill out the Child Asthma Plan and return it to the center.
5. A Routine Medication Record is used as a record of administered medications for each child when the child is not exhibiting any symptoms of difficulty in breathing.
6. An Emergency Medication Record is used when the child is having difficulty breathing.
7. An agreed-upon location for the medication forms is established at each site. Once filled, the forms will be saved in the family file.



COMMUNITY CHILD CARE COUNCIL OF SONOMA COUNTY, INC.

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CHILD ASTHMA PLAN

Parents/Guardians: Please note, to insure the best possible care for your child, it is required that this form be completed by your physician and returned to the center by the following date:_____.

Patient's Name:_____ DOB:_____

Medical Record #:_____

Parent/Guardian emergency phone #:_____

Healthcare Provider's Name:_____

Phone:_____

Date:_____

KNOWN TRIGGERS: _____

Routine Medications (use every day to stay healthy)	How Much to Take	How Often	Other Instructions (such as spacer/masks, nebulizers)
		_____ Times per day, EVERYDAY	
		_____ Times per day, EVERYDAY	
		_____ Times per day, EVERYDAY	

Emergency Medications	How Much to Take	How Often	Other Instructions

**NEBULIZER CARE CONSENT/VERIFICATION
CHILD CARE FACILITIES**

This form may be used to show compliance with Health and Safety Code Section 1596.798 before a child care licensee or staff person administers inhaled medication to a child in care. A copy of the completed form should be filed in the child's record and in the personnel file. ***A separate form must be filled out for each person who administers inhaled medication to the child.***

I, _____, give my consent for _____,
(PRINT NAME OF AUTHORIZED REPRESENTATIVE) (PRINT NAME OF LICENSEE OR STAFF PERSON)

who work(s) at _____,
(PRINT NAME AND ADDRESS OF CHILD CARE FACILITY)

to administer inhaled medication to my child, _____, and to contact my child's health care
provider. (PRINT NAME OF CHILD)

In addition, I certify that I have personally instructed the above-named licensee or staff person on how to administer inhaled medication to my child.

I have also provided the child care facility with written instructions from my child's physician, or from a health care provider working under the supervision of my child's physician (for example, a physician's assistant, nurse practitioner or registered nurse). These instructions include:

- Specific indications (such as symptoms) for administering the inhaled medication in accordance with the physician's prescription.
- Potential side effects and expected response.
- Dose form and amount to be administered in accordance with the physician's prescription.
- Actions to be taken in the event of side effects or incomplete treatment response in accordance with the physician's prescription. This includes actions to be taken in an emergency.
- Instructions for proper storage of the medication.
- The telephone number and address of the child's physician.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

DATE

ADDRESS OF AUTHORIZED REPRESENTATIVE

HOME TELEPHONE NUMBER

WORK TELEPHONE NUMBER

PERMISSION TO ADMINISTER MEDICATION

As the parent or legal guardian of _____

I give the staff of the child development center permission to administer this prescribed medication to my child on this date.

Medication _____ Doctor's note: Yes ___ No ___

Dose _____ Times / Administered by _____ / _____
_____ / _____
_____ / _____

Signature of Parent/Legal Guardian

Date

PERMISO PARA ADMINISTRAR MEDICINAS

Como Padre ó Guardián de _____, le doy permiso a los empleados del Centro de Desarrollo de Niño, para administrar esta(s) medicinas recetada(s) a mi hojo(a) en los siguientes días y horas.

Medicina _____ Nota del Doctor: Si ___ No ___

Dosis _____ Tiempo/Administrada por: _____ / _____
_____ / _____
_____ / _____

Firma del Padre ó Tutor Legal

Fecha