Minnesota JCC
Sabes Center Minneapolis

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Minneapolis, MN 55416
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early childhood center

2025-2026 Program Year

asthma/reactive airway disease (RAD) individual child care plan (page 1 of 2)

Child's Name_____ **Birthdate** _____

Allergies_____ **Reason for Prescribing** _____

EMERGENCY PHONE NUMBERS

Parent/Guardian 1 Name_____

Home #_____ Cell #_____ Work # _____

Parent/Guardian 2 Name_____

Home #_____ Cell #_____ Work # _____

Primary Physician Name_____ Emergency Phone _____

Asthma Specialist's Name_____ Emergency Phone _____

TO BE COMPLETED BY HEALTHCARE PROVIDER

Known triggers for this child's asthma (circle all that apply):

Are there any activities for which this child has needed special attention in the past?

- ☐ Colds
- ☐ Powder/chalk dust
- ☐ Strong odors
- ☐ Tree pollens
- ☐ Foods:_____
- ☐ Weather changes
- ☐ Room deodorizers
- ☐ Grass
- ☐ Animals
- ☐ Smoke
- ☐ Flowers
- ☐ House dust
- ☐ Aerosol sprays
- ☐ Mold
- ☐ Exercise
- ☐ Excitement
- ☐ Other: _____

Special considerations: related to his/her asthma while at the program? (Check all that apply and describe briefly.)

- ☐ Modified physical or outdoor activities _____
- ☐ Emotional or behavior concerns_____
- ☐ Avoiding Certain Foods/Other _____

How often has this child needed urgent care from a doctor for an attack in the past six months? _____

Special physician/parent's orders:_____

please complete medication information on other side

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Medications for treatment of asthma/RAD for (Child's Name): _____

Name of Medication **to be given at ECC:**			
When to use, give specific symptoms (i.e. coughing, cold symptoms, wheezing)			
How to use (e.g. by mouth, by inhaler, with or without spacer, in nebulizer, with or without dilution, etc.)			
Amount (dose) of medication			
How soon treatment should start to work			
Expected benefit for the child			
Possible side effects, if any			

Reminders:

1. Notify parents immediately if emergency medication is required.

2. Get emergency medical help if:
   - the child does not improve 15 minutes after treatment and family cannot be reached **OR**
   - if (after treatment) child is working hard to breathe, grunting, refusing to play, flaring nostrils while breathing, having trouble walking or talking, has blue/gray lips or fingernails, is extremely agitated or sleeping, has sucking in of skin (on chest or neck) with breathing.

3. The child's doctor and the child care facility should keep a current copy of this form in the child's file.

I give permission for the ECC to follow this plan of care prescribed by the physician. I also give my permission to call the health care provider listed for any additional medical information about my child. I understand that a photo of my child, including my child's name, specific allergies and treatment will be posted at the ECC.

Parent/Guardian Signature:_____ Date: _____

Physician's Signature: _____ Date: _____

TRAINED CHILD CARE PROVIDERS:

1._____ Room: _____

2._____ Room: _____

Plan of care reviewed by:

Director: _____ Date:_____

Teacher: _____ Date: _____

Child Care Health Consultant:_____ Date: _____