EdAdvance
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School Age Programs
Caring for a Child with Asthma

Child's Name: ___________________________________

Signs/Symptoms
The following signs/symptoms may be present when an asthma attack is developing:

- Coughing
- Wheezing
- Chest tightness, shortness of breath
- Increased pulse and respiratory rate
- Pale skin color

Additional Instructions from parent: (please include symptoms/triggers specific to your child)

____

____

____

What to do if the child develops symptoms while at the program:

- Help the child stay calm
- Have the child sit in the position that they are most comfortable and rest
- Guide the child in relaxed, controlled breathing
- If applicable follow directions for Authorization of Administration of Medication
- Call 911 if child's breathing becomes more difficult or he/she is struggling to breathe or unable to speak
- Call the parent to inform of the asthma episode

The following medications have been prescribed for this child's diagnosis of asthma:

____

____

Dear Parent:

Please assure that the steps above have been reviewed with you by EDADVANCE staff and that it is consistent with your wishes for care of your child while at he/she is attending the EDADVANCE School Age Program and is in agreement with instructions from your child's health care provider. Please note any additional instructions in the section provided. Thank you.

____ _____________________________
Parent Signature Date

Attention Staff! Please be sure that the following items are in the child's file:

- ☐ Completed Health Form
- ☐ Completed Administration of Prescription Medication Form
- ☐ Medication
- ☐ Completed Emergency Card

____ _____________________________
Parent Signature Date

WRITTEN ORDER FROM AN AUTHORIZED PRESCRIBER/PARENT'S PERMISSION for an **Emergency Medication**

If a Child Day Care Center, a Group Day Care Home or Family Day Care Home chooses to administer medications, the Connecticut State Law and Regulations require a physician, dentist, advanced practice registered nurses' written order and parent or guardian's authorization for a nurse, the director, teacher, or day care provider to administer medications. ***Prescription medications* must be in the original pharmacy prepared containers and labeled with the name of the child, name of drug, strength, dosage, frequency, name of prescriber, and date of original prescription**. **Over the counter medication must be in the original container and labeled with the child's name.**

PHYSICIAN, DENTIST, ADVANCED PRACTICE REGISTERED NURSE OR PHYSICIAN ASSISTANT

1. Name of Child: ______________________________ Date of Birth**:** ____________

Address**:** ____

Condition for which **medication** is being administered during day care hours: ______________

2. **Medication**: ______________________ Date of Order ______________

3. Dose ____________ **4. Route:** ______________ **5. Time** ____________

Medication shall be administered from**:** ______________ **To** ______________

(Date) (Date)

Side effects to be observed, if any**:** ______________________ see package insert ______

Plan for management of side effects _____call parent ______call health care provider ____other____________

Is this a controlled medication_________ Allergies to food or medication? If yes, list ______________

Interaction of medication with food**:** ______________________________

Name of **Licensed** Prescriber______________________Telephone______________________

(Type or Print)

Address: ____

Licensed Prescriber's Signature**:** ______________________ Date: ______________

AUTHORIZATION BY PARENT/GUARDIAN FOR THE ADMINISTRATION OF THE ABOVE MEDICATION:

I hereby request that the above medication, ordered by the physician/dentist/advanced practice registered nurse for my child ______________________, be administered by the nurse, director, or teacher. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that I must supply the Child Day Care Center, Group Day Care Home or Family Day Care Home with the prescribed medication in the original container dispensed and properly labeled by a physician or pharmacist. Over the counter medication shall be in the original container labeled by the parent with the child's name. I understand that this medication will be destroyed if it is not picked up within one week following termination of the order.

I authorize my child care provider/program to contact the pharmacist or prescriber for more information, if necessary, about this drug and side effects: ________Yes ___________No

Name Parent/Guardian (Print) ______________________________________

Parent Address: ______________________________________

Relationship to Child__________________________ Telephone ______________________

Parent Signature: __________________________Date: ______________________

For Controlled Substances, Child Care and parent/guardian must fill out following:

Amount/Quantity Received: __________

Child Care Provider Signature: ______________________Date: ______________

Parent Signature: ______________________________Date: ______________

Signature of Certified Child Care Provider receiving and reviewing this for:

______________________________ ______________________

(Signature) (Date)