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

Staff Signature: ________________________________ Date ________________________________
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:** ____________
2. **Address:** _____________________________________________
3. **Condition for which medication is being administered during day care hours:** ______________
4. **Medication:** ____________________________________________  
   **Date of Order** ___________________________
5. **Dose** __________________
6. **Route:** ____________________________  
   **Time** __________________
7. **Medication shall be administered from:** ___________________________  
   **To** ____________________________
   **(Date) (Date)**
8. **Side effects to be observed, if any:** ________________________________________________  
   see package insert ______
9. **Plan for management of side effects:**
   ________ call parent ________ call health care provider ________ other ________
10. **Is this a controlled medication:** ________  
11. **Allergies to food or medication?** If yes, list ____________________________
12. **Interaction of medication with food:** ____________________________
13. **Name of Licensed Prescriber:** ________________________________  
   **Telephone** ____________________________
   **(Type or Print)**
14. **Address:** _____________________________________________
15. **Licensed Prescriber’s Signature:** ___________________________________  
   **Date:** ______________________

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

1. **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.
2. **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
3. **Name Parent/Guardian (Print) ________________________________
   **Telephone** ____________________________
4. **Parent Address:** ____________________________________________
5. **Relationship to Child ____________________________
   **Telephone** ____________________________
6. **Parent Signature:** ___________________________________  
   **Date:** ______________________

### FOR CONTROLLED SUBSTANCES

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

1. **Amount/Quantity Received:** __________
2. **Child Care Provider Signature:** ________________________________  
   **Date:** ______________________
3. **Parent Signature:** ___________________________________  
   **Date:** ______________________

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

(Signature) ____________________________________________________________  
**(Date) ____________________________________________________________**