

Launchpad Preschool Medical Condition/Allergy/Asthma Medical Plan

This form/plan must be completed each school year and signed by a medical provider

Child's Name: _____ DOB: _____ Class: _____

Medical Condition: _____

Symptoms/Signs of Medical condition _____

ALLERGY TO: _____

Asthmatic: Yes* _____ No _____ *Higher risk for severe reaction

Allergy Symptoms and Action Plan (circle all symptoms that apply; use the blank line for action plan)

*If a food allergen has been ingested, but NO symptoms _____

Mouth: Itching Tingling Swelling of lips, tongue, mouth _____

Skin: Hives itchy Rash Swelling of face, extremities _____

Gut: Nausea Abdominal cramps Vomiting Diarrhea _____

Throat: Tightening of throat Hoarseness Hacking cough _____

Lung: Shortness of breath Repetitive coughing Wheezing _____

Heart: Thready pulse Low blood pressure Fainting Pale Blueness _____

Other: _____

Medication/Dosage: *(original RX box/medication box required)* Epi Pen: Yes _____ No _____

Emergency Plan (indicate in the blank when to initiate emergency plan)

Call 911 _____

Dr. _____ @ _____

Emergency Contacts:

Name _____ Phone# _____ # _____

Name _____ Phone# _____ # _____

Even if Parent/Guardian Cannot be reached, Do Not hesitate to medicate or take child to medical facility.

Parent Signature _____ Date: _____

Doctor's Signature _____ Date: _____

Care Plan for child with Asthma

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

- | | | | |
|-----------------------|------------|-----------------|------------------|
| Colds | Exercise | Tree pollens | House |
| Dust | Excitement | Strong odors | Smoke |
| Mold | Animals | Weather changes | Grass/Flowers |
| Foods (specify) _____ | | | Room deodorizers |
| Other (specify) _____ | | | |

Activities for which this child has needed special attention in the past (circle all that apply)

Outdoors

Indoors

- | | |
|-----------------------------|---|
| Running hard | Art projects with chalk, glues, fumes |
| Gardening/cut Grass | Sitting on carpet/rugs |
| Jumping in leaves | recent Pesticides application in facility |
| Outdoors on cold/windy days | Painting/renovations in facility |

How often has this child needed urgent care from a doctor for an attack of asthma:

In the past 12 months? _____ in the past 3 months? _____

Typical signs/symptoms of the child's asthma episodes (circle all that apply)

- | | | |
|-------------------------|---|----------------------------------|
| Fatigue | Persistent coughing | Gray or blue lips or fingernails |
| Wheezing | Sucking in chest/neck | |
| Grunting | Face red, pale or swollen | |
| Breathing Faster | Difficulty playing, eating, drinking, talking | |
| Restlessness/agitation | Flaring nostrils, mouth open (panting) | |
| Dark circles under eyes | Complaints of chest pain/tightness | |