SHINING SMILES
Daycare

Asthma Health Care Plan

Child Name: _____ **Date of Birth:** _____

Physician Name: _____ **Phone:** _____

Parent/Guardian Name: _____ **Phone:** _____

This form is to be completed by parent(s)/guardian(s) when asthma and its related triggers has been identified and medically diagnosed by my child's physician

*** To be completed by child's medical provider ***

Severity:

- ☐ Mild
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Check ALL Triggers

- ☐ Smoke (Cigarette)
- ☐ Cold/Flu
- ☐ Strong Odor (Identify): _____
- ☐ Temperature Changes
- ☐ Ozone Alert
- ☐ Exercise (Identify): _____
- ☐ Dust
- ☐ Wood Smoke
- ☐ Pet Dander
- ☐ Flowers/Grass/Pollen
- ☐ Mold
- ☐ Food: _____
- ☐ Cleaning Products: _____
- ☐ Others: _____

Suggested classroom strategies to support this child's needs:

_____

_____

Specific Medical Information

Is there medication that needs to be administered: ☐ Yes ☐ No

If Yes, medication to be please complete the *Medication Authorization Form*

Potential Side Effect of Medication:

_____

_____

Potential Consequences to Child if Treatment is NOT Administered:

_____

_____

Additional Emergency Procedures/Instructions:

_____

_____

Physician Acknowledgement

_____ Physician Signature	_____ Date
_____ Parent/Guardian Signature	_____ Date
_____ Shining Smiles Representative Signature	_____ Date

Parent/Guardian Acknowledgement Statement

To ensure the safety of your child I (parent/guardian) cannot delete/change a healthcare diagnosis that has been previously documented unless I have a signed note from the child's physician stating that the condition no longer exists; nor can we add an information or change a medication without a signed note from the child's physician.

I understand that Shining Smiles requires the most current information regarding my child's allergy. I also understand that for the safety of my child, my child's photograph and allergy information will be posted in the classrooms and kitchen (where applicable).

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

•For complete medication administration information, it may be necessary for the medical provider and parent/guardian to complete the *Medical Authorization Form*