# INDIVIDUALIZED PLAN FOR A CHILD WITH AN ASTHMATIC CONDITION

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| Child’s Name: | |
| Child's Date of Birth (dd/mm/yyyy): | |
| List of allergen(s)/causative agent(s): | |
| Medication name and dosage/puffs: | |
| Medication expiry date (mm/yyyy): | **Location of Medication:**  On Educator or  On Child |
| Other emergency medications: | Location of medication storage: |

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| SIGNS AND SYMPTOMS: (specific to the child, e.g. wheezing and coughing) |
| PROCEDURE TO FOLLOW IF CHILD HAS A REACTION: |
| STEPS TO REDUCE RISK OF EXPOSURE TO CAUSATIVE AGENT/ALLERGEN: (e.g. wash hands frequently, limit outdoor play in extreme weather) |
| STEPS TO FOLLOW DURING AN EVACUTATION OR AN OFF-SITE EXCURSION/FIELD TRIP: |
| **DESCRIPTION OF MEDICAL DEVICES USED BY THE CHILD AND INSTRUCTIONS ON THEIR USE:** |
| **SUPPORTS AVAILABLE TO THE CHILD** (if applicable)**:** *(e.g. nurse or trained staff to assist with feeding and/or disposing and changing of stoma bag; or not applicable (N/A))* |

| Photo of Child (recommended) |
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## EMERGENCY CONTACT INFORMATION

| Contact Name | Relationship to Child | Primary Phone Number | Additional Phone Number |
| --- | --- | --- | --- |
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**PARENTAL STATEMENT**

I \_\_\_\_\_\_\_\_\_\_ (parent/guardian) hereby give consent for my child \_\_\_\_\_\_\_\_\_\_\_(child’s name) to (check all that apply):

self-carry their emergency asthma medication on their body

self-administer their own medication in the event of a reaction

AND/OR

I ­­­­­\_\_\_\_\_\_\_\_\_\_\_ (parent/guardian) hereby give consent to any person with training on this plan at the child care premises to administer my child’s asthma medication and to follow the procedures set out in my child’s Individualized Plan.

This plan has been created in consultation with the child’s parent / guardian.

### SIGNATURE OF PARENT/GUARDIAN (required)

|  |  |
| --- | --- |
| Print name: | Relationship to Child:  Click here to enter text. |
| X | Date:  Click here to enter text. |

The following individuals participated in the development of this individual plan (optional):

|  |  |  |
| --- | --- | --- |
| First and Last Name | Position/Role | Signature |
|  |  |  |

This plan will be reviewed and updated annually or as needed.