Year: ____________

PO Box 1117 1602 W. Ferguson Rd
Mt. Pleasant TX 75455
(903)575-2092 fax (903)575-2077

Asthma Care Plan

Child's name/*Nombre del Niño*	Birthday/*Fecha de Nacimiento*	Room/*Salón*

To be filled out by parent:

Parent/Guardian Name: ____ Phone number: ______________

Doctor: ________________________ Address: _____________________ Phone number: ______________

Hospital: _______________________ Address: _____________________ Phone number: ______________

To be filled out by parent/*Llenado por padre*:

Has a medical doctor diagnosed your child with asthma? *Su hijo(a) ha sido diagnosticado(a) con asma por un médico?*
Yes/Si_________ No_________

How severe would you rate your child's asthma (Make a check in the box that applies most)/*Cómo calificaría la severidad del asma (Marque lo más apropiado)* Severe/*Severa*______,
Somewhat Severe/*Algo Severa* ______,
Very Severe/*Muy Severa*______

How many asthma attacks has your child had in the past?/ *¿Cuantos ataques de asma ha tenido su hijo(a) en el pasado?* One Month/*Un Mes* ______, Six Months/*Seis Meses* ______, Year/*Un Ano*______, Lifetime/*Toda su Vida*______

Has your child been hospitalized for asthma?/ *Su hijo(a) ha estado hospitalizado(a) por el asma antes?*
Yes/*Si* _____ No______
If Yes, when? _______________________________

Identify all the things that trigger an asthma attack in your child/ *Identifique toda las cosas que causan los ataque de asma a su hijo(a):*
Animals/Animales______, Dust/Polvo______, Chemicals/Quimicos______, Smoke/Humo______, Change in temperature/Cambio del Clima______, Food/Comidas______, Illness/Enfermedades______, Exercise/Ejercicio______, Strong Odors/Olores fuertes______, Insects/Insectos_______, Mold/Pollen/Moho/Polen _______,
Other (Please describe)/Otro (Porfavor describa) _______________________

Does your child take medication for asthma?/ *¿Su hijo(a) toma medicamento para el asma?*
Yes_______ No________

Does your child need any special consideration related to his or her asthma while at school (Check all that apply)/ *Su hijo(a) necesita una consideración especial relacionada con su asma mientras esta en la escuela (Marque todo lo que aplique):*
Modify recess outside/Modificacion a la hora de recreo_______, No animal or pets in classroom/No animals o mascot en el salon_______, Avoiding certain foods/Evitar ciertas comidas_______, Modification for field trips/Modificacion en viajes escolares_______,
Other (Please Specify)/Otro (Porfavor especifique)__________________________

Continued on the Back/ *Continuado atras*

Year: ____________

To be filled out by Doctor/*Llenado por Doctor*:

Medication (Medicamentos)

List all medication your child takes for asthma/ Escriba todos los medicamentos que su hijo(a) toma para el asma		
Name of Medication/ Nombre del medicamento	**Dose of medication Dosis de medicamento**	**Frequency of medication Frecuencia del medicamento**

Emergency Action Plan/ *Plan de acción en caso de emergencia:* ______________________________________
____
____
____
____
____

I give the school permission to administer the asthma care plan.

Parent or Guardian Signature/Firma del Padre o Tutor: ____________________________ Date: ____________

Doctor Signature/Firma del Doctor: ____ Date:____________

Teacher Signature/Firma del Maestro(a): ____ Date: ____________

Cafeteria Manager Signature/Firma del Gerente de Cafeteria: ______________________ Date: ____________

Health Staff Signature/Firma de Personal de Salud: _______________________________ Date: ____________