Name: ____________________________________________
Grade: ___________________________ DOB: ___________________________
Parent/Guardian Name: ______________________________________________
Address: __________________________________________________________
Phone (H): ___________________________ (W): ___________________________
Parent/Guardian Name: ______________________________________________
Address: __________________________________________________________
Phone (H): ___________________________ (W): ___________________________
Other Contact Information: ___________________________________________
Emergency Phone Contact #1 __________________________________________
Name ____________________________________________
Relationship ____________________________________________ Phone: ___________
Emergency Phone Contact #2 __________________________________________
Name ____________________________________________
Relationship ____________________________________________ Phone: ___________

Physician Child Sees for Asthma/Allergies: __________________________________
Phone: ___________________________
Other Physician: ____________________________________ Phone: ___________

• Daily Medication Plan for Asthma/Allergy

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
<th>When to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OUTSIDE ACTIVITY AND FIELD TRIPS The following medications must accompany child when participating in outside activity and field trips:

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
<th>When to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This document may be reproduced, provided credit is given to AAFA
Rev. 5/01
ASTHMA EMERGENCY PLAN
Emergency action is necessary when the child has symptoms such as ________________
or has a peak flow reading at or below _____________________________

• Steps to take during an asthma episode:
  1. Check peak flow reading (if child uses a peak flow meter).
  2. Give medications as listed below.
  3. Check for decreased symptoms and/or increased peak flow reading.
  4. Allow child to stay at child care setting if: ________________________________

  5. Contact parent/guardian
  6. Seek emergency medical care if the child has any one of the following:

  → No improvement minutes after initial treatment with medication.
  → Peak flow at or below ________________
  → Hard time breathing with:
    ➢ Chest and neck pulled in with breathing.
    ➢ Child hunched over.
    ➢ Child struggling to breathe.
    ➢ Trouble walking or talking.
    ➢ Stops playing and cannot start activity again.
    ➢ Lips or fingernails are gray or blue.

ALLERGY EMERGENCY PLAN
• Child is allergic to: ________________________________

• Steps to take during an allergy episode:
  1. If the following symptoms occur, give the medications listed below.
  2. Contact Emergency help and request epinephrine.
  3. Contact the child's parent/guardian.

• Symptoms of an allergic reaction include:
  (Physician, please circle those that apply)

  → Mouth/Throat: itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
  → Skin: hives; itchy rash; swelling
  → Gut: nausea; abdominal cramps; vomiting; diarrhea
  → Lung*: shortness of breath; coughing; wheezing
  → Heart: pulse is hard to detect; “passing out”
  *If child has asthma, asthma symptoms may also need to be treated.

IF THIS HAPPENS, GET EMERGENCY HELP NOW!

• Emergency Asthma Medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
<th>When to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Emergency Allergy Medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Amount</th>
<th>When to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Special Instructions:

  ____________________________________________________________

  ____________________________________________________________

  ____________________________________________________________

  ____________________________________________________________

Physician's Signature __________________________ Date __________
Parent/Guardian's Signature __________________________ Date __________
Child Care Provider's Signature __________________________ Date __________

Asthma and Allergy Foundation of America • 1234 20th Street, N.W., Suite 402, Washington, DC 20036 • www.aafa.org • 1-800-7-ASTHMA