Tyndall Airman and Family Services Flight

325 FSS, Tyndall AFB, FL

ASTHMA CARE PLAN

CHILD'S NAME: ______________________________________ **DOB:** _______________

Program Enrollment: [X]CDC [ ]FCC [ ]SAP [ ]EFMP

Has your child been diagnosed with Asthma? YES NO

Has your child been hospitalized for Asthma? YES NO If yes, date of last admission: __________

What are your child's asthma triggers? ____

____

List typical signs and symptoms that signal an episode of asthma in its early stages: _________________

____

List symptoms that signal an episode of asthma has progressed and required parental or medical intervention: ____

____

Actions to take until child's parents arrive, or medical intervention is available: _____________________

____

____

DAILY MEDICATION INFORMATION

MEDICATION	DOSE	EXPECTED BENEFIT	SIDE EFFECTS
1.			
2.			

PRN MEDICATIONS OR MEDICATION THAT IS ONLY USED AS NEEDED

PRN MEDICATION	DOSE	EXPECTED BENEFIT	WHEN TO GIVE	SIDE EFFECTS
1.				
2.				

(Medication information provided above does not replace required AF Form 1055, Youth Flight Medication Permission)

Additional Instruction: ____

____

____

Specialized training required to administer medication: YES NO If yes, what type: _____________

____

______________________________ ______________________________ ____________

Parent Name (please print) Parent Signature Date

____ ____________

Medical Provider's Name and Stamp Date

______________________________________ ____________________

Medical Facility Phone Number

This Asthma Care Plan must be reevaluated in no more than 12 mos from date above.