



Respiratory Health Care Plan - Parent/Guardian Form

(This page is to be completed by the parent/guardian of the child)

Child's Name: _____

Center: _____ Rm #: _____

Family Information	Health Care Provider Information
Parent/Guardian's Name:	Name of Health Care Provider:
Home Phone #: Work #:	Phone #:
Emergency Contact:	Emergency Contact:
In Emergency, Call:	In Emergency, Call:
Phone #:	Phone #:

My Child's Medications (Authorization of Medication form to be completed monthly)			
Name of Medication:	When to take it:	Device Used:	Medication Expiration:

What is currently being done at home to support the child when they get sick: _____

Reason why child needs to have this medication at school: _____

By signing this form, you consent for us to exchange information with your child's healthcare provider as needed. You certify that you have personally instructed the teaching staff on how to administer inhaled medication to your above-named child and give consent to implement the instructions provided by your child's health care provider (in compliance with CCL Health & Safety Code Section 1596.798).

Parent/Guardian Signature: _____ Date: _____

Kidango Staff Signature/Title: _____ Date: _____

Kidango Staff Review Initial and Date:

Staff Initial: _____ Staff Initial: _____ Staff Initial: _____ Staff Initial: _____

Date: _____ Date: _____ Date: _____ Date: _____

**This plan and the Authorization for Medication Form must be completed, on file, and reviewed with the Center Director, Teacher, or designated Kidango staff before the child can be accepted for childcare services. Please make a copy for the child's parent/guardian.*

Respiratory Health Care Plan - Physician's Instructions

(This page is to be completed by the child's Physician/Health Care Provider in accordance with Community Care Licensing Health & Safety Code.)

Child's Name: _____ DOB: _____

Physician's Name: _____

Physician's Phone Number: _____

Physician's Signature: _____

Date: _____

Physician Stamp:

Prescribed Medication to Keep at School	How Much to Take (dosage)	How Often	Other Instructions (spacers, masks, nebulizers)
		_____ times per day	
Medication Potential Side Effects:		Proper Storage Instructions:	

Reason medication is being prescribed:

- Chronic Asthma Management
- Temporary Respiratory Condition (e.g., post-viral cough, wheezing)
- Other: _____

How long should the medication at school be kept at school? _____

Specific Indications/Symptoms for Administering Inhaled Medication:

Green Zone:	Yellow Zone:	Red Zone:	Health Care Provider's Additional Notes/Instructions:
Child is well and has no difficulty breathing.	Child is NOT well and has symptoms that may include: <ul style="list-style-type: none"> Coughing Wheezing Runny nose Breathing harder or faster 	Child feels awful! <ul style="list-style-type: none"> Coughing and/or wheezing continues or worsens Breathing difficulty- child has trouble walking or talking 	
Staff Plan of Action	Staff Plan of Action:	Staff Plan of Action	
Monitor and Prevent: Check in with the parent/guardian to see if the child is taking controller preventive medications at home.	Move the child to a quiet setting; administer quick relief medication as instructed.	Call 911 and notify the parent/guardian!	