Child Health Plan and Provider Orders Form - Respiratory Disorder

Early Learning psesd excellence & equity in education Puget Sound Educational Service District

Center: _____ ☐ Early Head Start ☐ Head Start ☐ ECEAP

Child's Name: _____ DOB: _____ Gender: M / F

Parent/Guardian: _____ Phone: (H) _____ (C) _____

This child has been diagnosed with: ☐ Asthma ☐ RAD ☐ RSV (EHS only)
If asthma, please check level of severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Seasonal/When ill

When was your child's last episode? _____

What steps did you take to resolve it? _____

_____

What will your child say or do during an episode? _____

_____

What symptoms occur when your child has an episode? (check all that apply)
☐ Coughing ☐ Wheezing ☐ Shortness of Breath ☐ Tight Chest ☐ Tired ☐ Other: _____

Call 911, then Parent/Guardian for the following signs and symptoms:

- Symptoms above continue for 10 minutes after giving medication
- Difficulty talking or walking
- Continuous coughing
- Chest, neck, or ribs sucking in
- Lips or fingernails turning pale or blue
- Bending over to breath
- Gasping for air

What makes your child's ability to breathe worse? (check all that apply)
☐ Colds/Viruses ☐ Exercise ☐ Crying/Upset ☐ Laughing too hard
☐ Tobacco Smoke ☐ Chemicals ☐ Pollen ☐ Dust ☐ Mold
☐ Cold temperatures ☐ Change in weather ☐ Animals ☐ Cockroaches
☐ Foods/Other (list): _____

Is medication(s) taken at home? ☐ Yes ☐ No (list): _____
Is medication(s) needed while at school? ☐ Yes ☐ No (If YES, refer to provider order's)
Is medication(s) needed during transport to/from school? ☐ Yes ☐ No

Child's Name: _____ DOB: _____ Gender: M / F

☐ No medication is required at school (Please sign below if you agree with this CHP).

Health Care Provider Orders for Medication at School

Important notice to provider:
Please ensure this child has a prescription on file with the pharmacy that matches the orders below. **Our policy requires Health Care Provider Orders and medication labels to match exactly.**

1) Medication Name 2) Symptoms for medication use

3) Dose 4) Frequency & Length of time between doses 5) Route

6) Possible side effects of medication

7) Special administration and/or storage instructions

8) If PRN specify Start date: _____ AND End date: _____

Health Care Provider's Signature Date

Print name Phone # Fax #

Parent/Guardian Signature Date

Interpreter Signature Date

Reviewed by: Health or Nutrition Coordinator / Nurse Consultant Date

ITE/Teacher Date ITP/Assistant Date FA/FE/FSF/HV Date Dir/C Coor Date