Individual Child Care Program Plan (ICCPP) for Asthma/Reactive Airway Disease

Form I-300

Child's Name: Date of Birth:

EMERGENCY PHONE NUMBERS

Parent/Guardian #1 - Name and Phone:

Parent/Guardian #2 - Name and Phone:

*See emergency contact information for alternate if parent/guardian not available

Primary health provider's name and phone:

Asthma specialist's name and phone (if any):

INSTRUCTIONS FROM A HEALTH CARE PROVIDER

Known triggers (circle all that apply)

colds	aerosol sprays	grass	aerosol sprays	mold
powder/dust	flowers	animals	flowers	exercise
strong odors	excitement	house dust	excitement	
food (specify):				
other (specify:				

Activities for which the child has needed special attention (outdoor or indoor):

Special considerations while in the program (check and explain)

__ Modified physical activities:
__ Modified outdoor times or activities:
__ No animal pets in classroom:
__ Avoiding certain foods:
__ Emotional / Behavioral concerns:
__ Special consideration while on field trips:

Can the child use a flow meter to monitor need for medication in child care? Yes ◯ No ◯

Best Peak flow reading:

Reading to give extra medication:

Reading to get help:

How often has the child needed urgent care from a doctor in the past 6 months?

Special provider orders:

-Over-

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ICCPP For Asthma / Reactive Airway Disease

MEDICATIONS

GREEN ZONE (have ALL of these) Breathing is good No cough/wheeze Can play easily Sleep all night	**NAME:**	**DOSE:**	**WHEN:**

these controller medications are taken daily

YELLOW ZONE (have ANY of these) Hard to breath Coughing Wheezing Tightness in chest Cannot play easily Wake at night coughing	**NAME:**	**DOSE:**	**WHEN:**

take green zone medications and ADD quick relieving medication

RED ZONE (have ANY of these) Very hard to breath Nostrils flaring Ribs are showing Medications not helping Trouble waking/talking Lips or fingers are grey/blue	**NAME:**	**DOSE:**	**WHEN:**

*take quick-relief medication **NOW and call 911***

Health Care Provider Signature: **Date:**

Parent/Guardian Signature: **Date:**

TRAINED CHILD CARE PROVIDERS: **(full printed name, signature and date trained)**

*Must be reviewed with any changes to the plan. If needed, attach more signatures to form:

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Date current ICCPP was crated:

Plan of care written in collaboration with (Director/Center Representative):

Projected date of plan re-evaluation (done at least yearly):