INHALER CARE PLAN

CENTER _____

Child's Name _____ DOB _____

Asthmatic Yes ☐ No ☐

Triggers: _____

Symptoms: _____

Medication ordered: _____

Other: _____

EMERGENCY PLAN

STEP 1 _____

STEP 2 _____

STEP 3 _____

Parent/Guardian Signature: _____ Date: _____

Site Director Signature: _____ Date: _____

Program Director Signature: _____ Date: _____

Executive Director Signature: _____ Date: _____

TLC Staff Signature: _____ Date: _____

TLC Staff Signature: _____ Date: _____

TLC Staff Signature: _____ Date: _____

TLC Staff Signature: _____ Date: _____

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All TLC staff must review, sign and date. Additional room on back.

TLC Staff Signature: _____ Date: _____

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