INHALER CARE PLAN

Childle Name						CENTER	
Child's Name Asthmatic	Yes	1	1	No	1	DOB	
Astimatic	163			NO	<u> </u>		
Triggers:							
Symptoms:							
Medication o	rdered:						
Other:							
Otner:							
			<u>EMER</u>	GENCY	<u>PLAN</u>		
STEP 1							
0.1.							
STEP 2							
STEP 3							
Parent/Guard	lian Signa	ture:				Date:	
Cita Disease (3 .					Data	
Site Director S				Date:			
Program Direct				Date: Date:			
Executive Director Signature:						Date:	
TLC Staff Signature: TLC Staff Signature:						Date:	
TLC Staff Sign				Date:			
TLC Staff Signature:						Date:	
TLC Staff Sign				Date:			
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TLC Staff Signature:						Date:	
TLC Staff Signature:						Date:	

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

TLC Staff Signature:	Date:
TLC Staff Signature:	Date:
TLC Staff Signature:	Date: