Child's Name _____

DOB _____

EdAdvance BASES
860-567-0863 x1167
355 Goshen Road, Litchfield, CT 06790

BASES Student Care Plan

Individualized Plan of Care for a Child with Special Health Care Needs or Disabilities

* Staff must refer to Medication Administration forms or complete dosing and administration instructions*

ASTHMA ☐ Yes ☐ No

Medication _____ Time ☐ Onset of Attack ☐ Prior to Exercise

The following signs/symptoms may be present when an asthma attack is developing

☐ Coughing ☐ Wheezing ☐ Chest tightness/shortness of breath

☐ Pale skin color ☐ Increased pulse/respiratory rate

Additional instructions (symptoms, triggers, etc.) **See Attached Asthma Action Plan and Medication Authorization from PCP**

What to do if a child develops symptoms while at the program

- Help the child stay calm
- Have the child sit in the position that they are most comfortable and rest
- Guide the child in relaxed, controlled breathing
- If applicable follow directions for Authorization of Administration of Medication
- Call 911 if child's breathing becomes more difficult or he/she is struggling to breathe or unable to speak
- Call the parent to inform of the asthma episode

ANAPHYLAXIS ALLERGY ☐ Yes ☐ No

Allergy to: _____ ☐ Ingestion Only ☐ Contact or Ingestion

See Attached Treatment/Emergency Plan and Medication Authorization from PCP

If exposure (see above) or insect sting is witnessed or suspected caregiver should

_____ Administer Adrenalin (injectable medication) BEFORE symptoms occur

_____ Administer Adrenalin (injectable medication) IF symptoms occur

_____ Administer Benadryl dose

_____ Administer Adrenalin (injectable medication) _____ FOR _____

_____ Call 911 Transport to Emergency Room if symptoms occur and/or adrenalin is administered

Relevant side effects to be observe, if any _____

NON ANAPHYLAXIS ALLERGY ☐ Yes ☐ No

Allergy to _____ Symptoms/triggers _____

☐ Will not be accesible/served at program ☐ Will keep away from allergin if possible exposure

OTHER HEALTH CONCERNS ☐ Yes ☐ No

Diagnosis _____ Current Medications _____

Relevant Information (symptoms, triggers, interventions etc) _____

_____

MEDICATIONS NOT ADMINISTERED AT THE PROGRAM ☐ Yes ☐ No

Medication Name	Medication Dose	Medication Dosage Schedule

ear Parent uar ian: Please assure that the ste s abo e ha e been re iewe with ou b E A an e ASES staff an that it is onsistent with our wishes for are of our hil while at he she is atten ing the E A an e ASES Program an is in agreement with instru tions from hil s health are ro i er Please note an a itional instru tions in the se tion ro i e

Parent/Guardian Signature _____ **Date** _____

ATTENTION STAFF: Please be sure that the following items are on file

☐ Completed Health Form ☐ Medication labeled in individual box/bag

☐ Completed Emergency Card ☐ Completed Administration of Prescription Medication Form is with the medication

NOTE: Section 19a-79-5a(a)(2)(E) requires a child's Health Record to include information regarding disabilities or special health care needs such as allergies, special dietary needs, dental problems, hearing or vision impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for the child with special health care needs or disabilities, The plan shall be developed with the child's parent(s) and health care provider and updated as necessary. Section 19a-79-4a(h)(2)(H)(viii) requires that the health care consultant shall assist in the review of individual care plans as needed.