COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

PARENT/GUARDIAN complete and sign the top portion of form.	
Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
Grade:	Teacher:

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Other: _____

☐ **Life threatening allergy** : Specify _____

If there is no quick relief inhaler at school and the student is experiencing asthma symptoms:

- Call parents/guardians to pick up student and/or bring inhaler/ medications to school
- Inform them that if they cannot get to school, 911 may be called

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

☐ 504 PLAN OR IEP

PARENT SIGNATURE _____ DATE _____ SCHOOL NURSE SIGNATURE _____ DATE _____

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: ☐ Not Required

Pretreatment for strenuous activity: ☐ Routinely **OR** ☐ Upon request Explain: (weather, viral, seasonal, other) _____

☐ Give 2 puffs of quick relief med (Check One): ☐ Albuterol ☐ Other: _____ 10-15 minutes before activity.

☐ Repeat in 4 hours if needed for additional or ongoing physical activity.

If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	DO THIS:
▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between _____ and _____ ▪ Other: _____	1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. ***If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.***

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < _____	1. GIVE QUICK RELIEF MED: (Check One): ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ ☐ Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs). 8. *School personnel should not drive student to hospital.*

INSTRUCTIONS for QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse.

☐ Student is to notify his/her designated school health officials after using inhaler.

☐ Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) _____.

HEALTH CARE PROVIDER SIGNATURE _____ PRINT PROVIDER'S NAME _____ PHONE/FAX _____ DATE _____

Copies of plan provided to: Teacher(s) ___ Phys Ed/Coach ___ Principal ___ Main Office ___ Bus Driver ___ Other _____

Asthma Self Carry Contract **School:** _____ **Grade:** _____

STUDENT : _____ **DOB:** _____

☐ I plan to keep my rescue inhaler with me at school rather than in the school health office.

☐ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office if I am having more difficulty than usual with my asthma.

☐ I will not allow any other person to use my inhaler.

Student's Signature _____ Date _____

PARENT/GUARDIAN: _____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.

☐ It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.

☐ I will review the status of the student's asthma with the student on a regular basis as agreed in the health care plan.

☐ I will provide the school a Health Care Provider signed medication authorization for this medication.

Parent's Signature _____ Date _____

Nurse Consultant _____ **School** _____

☐ The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.

☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.

☐ I will review the medication authorization provided by the parent and signed by the health care provider.

Nurse Consultant's Signature _____ Date _____

School Administrator's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Health Assistant Signature: _____ Date: _____

Allergy Self Carry Contract **School:** _____ **Grade:** _____

STUDENT : _____ **DOB:** _____

- ☐ I plan to keep my Epi-pen with me at school rather than in the school health office.
- ☐ I agree to use my Epi-pen in a responsible manner, in accordance with my physician's orders.
- ☐ I will notify the school health office immediately if my Epi-pen has been used.
- ☐ I will not allow any other person to use my Epi-pen.

Student's Signature _____ Date _____

PARENT/GUARDIAN: _____

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

- ☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.
- ☐ It has been recommended to me that a back-up Epi-pen be provided to the Health Office for emergencies.
- ☐ I will review the status of the student's allergy with the student on a regular basis as agreed in the health care plan.
- ☐ I will provide the school a signed medication authorization for this medication.

Guardian's Signature _____ Date _____

Nurse Consultant _____ **School** _____

- ☐ The above student has demonstrated correct technique for Epi-pen use, an understanding of the physician order for emergency use of the Epi-pen .
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.
- ☐ I will review the medication authorization provided by the parent and signed by the parent and health care provider.

Nurse Consultant's Signature _____ Date _____

School Administrator's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Health Assistant Signature: _____ Date: _____