

Photo of Child

**COLORADO SCHOOL ASTHMA CARE PLAN:**

NAME:	BIRTH DATE:
TEACHER:	GRADE:
PARENT/GUARDIAN:	CELL PHONE:
HOME PHONE:	WORK PHONE:
OTHER CONTACT:	PHONE:
PREFERRED HOSPITAL:	

Triggers:  Weather(cold air, wind)  Illness  Exercise  Smoke  Dog/Cat  Dust  Mold  Pollen Other: \_\_\_\_\_  
 Give 2 puffs of \_\_\_\_\_ rescue med  15 minutes before activity. Indications:  Phys Ed class  exercise/sports  Recess

Explanation:

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

<b>YELLOW ZONE: SICK – UNCONTROLLED ASTHMA (Health provider complete dosing for rescue inhaler)</b>	
<b>IF YOU SEE THIS:</b>	<b>DO THIS:</b>
<ul style="list-style-type: none"> <li>• Difficulty breathing</li> <li>• Wheezing</li> <li>• Frequent cough</li> <li>• Complains of chest tightness</li> <li>• Unable to tolerate regular activities but still talking in complete sentences</li> <li>• Other:</li> </ul>	<ul style="list-style-type: none"> <li>• Stop physical activity</li> <li>• <b>GIVE RESCUE MED (NAME):</b> _____  <input type="checkbox"/> 1 PUFF <input type="checkbox"/> PUFFS <input type="checkbox"/> OTHER: <input type="checkbox"/> VIA SPACER</li> <li>• If no improvement in 10-15 minutes, repeat use of rescue med:  <input type="checkbox"/> 1 PUFF <input type="checkbox"/> 2 PUFFS <input type="checkbox"/> OTHER: <input type="checkbox"/> VIA SPACER</li> <li>• If student's symptoms do not improve or worsen, call 911</li> <li>• Stay with student and maintain sitting position</li> <li>• Call parents/guardians and school nurse</li> <li>• Student may resume normal activities once feeling better</li> </ul>
<ul style="list-style-type: none"> <li>• <b>IF THERE IS NO RESCUE INHALER AT SCHOOL:</b> <ul style="list-style-type: none"> <li>➢ CALL PARENTS/GUARDIANS TO PICK UP STUDENT AND/OR BRING INHALER/MEDICATIONS TO SCHOOL</li> <li>➢ INFORM THEM THAT IF THEY CANNOT GET TO SCHOOL, 911 MAY BE CALLED</li> </ul> </li> </ul>	
<b>IF YOU SEE THIS: RED ZONE</b>	<b>DO THIS IMMEDIATELY:</b>
<ul style="list-style-type: none"> <li>• Coughs constantly</li> <li>• Struggles or gasps for breath</li> <li>• Trouble talking (only able to speak 3-5 words)</li> <li>• Skin of chest and/or neck pull in with breathing</li> <li>• Lips or fingernails are gray or blue</li> <li>• ↓ Level of consciousness</li> </ul>	<ul style="list-style-type: none"> <li>• <b>GIVE RESCUE MED (NAME):</b> _____  <input type="checkbox"/> 1 PUFF <input type="checkbox"/> 2 PUFFS <input type="checkbox"/> OTHER: <input type="checkbox"/> VIA SPACER</li> <li>• Repeat rescue med if student not improving in 10-15 minutes</li> <li>• 911 Inform attendant the reason for call is ASTHMA</li> <li>• Call parents/guardians and school nurse</li> <li>• Encourage student to take slower deeper breaths</li> <li>• Stay with student and remain calm</li> <li>• <i>School personnel should not drive student to hospital</i></li> </ul>

**INSTRUCTIONS FOR RESCUE INHALER USE: HEALTH PROVIDER: PLEASE 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

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

Student needs supervision or assistance to use his/her inhaler. If not self carry, the inhaler is located:

Student has life threatening allergy, the EpiPen is located:

HEALTH CARE PROVIDER SIGNATURE \_\_\_\_\_ PLEASE PRINT PROVIDERS NAME \_\_\_\_\_ START DATE \_\_\_\_\_ END DATE \_\_\_\_\_  
 Fax number \_\_\_\_\_ Phone Number \_\_\_\_\_

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.

PARENT SIGNATURE

DATE

SCHOOL NURSE SIGNATURE

DATE