

COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

| | |
|---------------------|-------------|
| 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: _____

GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health provider please complete section)

- Give 2 puffs of rescue med (*name*) _____ 15 minutes before activity (Circle indication: Phys Ed class, exercise/sports, recess) Explanation: _____
- Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA (Health provider complete dosing for rescue medication)

| IF YOU SEE THIS: | DO THIS: |
|---|---|
| <ul style="list-style-type: none"> ▪ Difficulty breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Unable to tolerate regular activities but still talking in complete sentences ▪ Other: | <ul style="list-style-type: none"> ▪ Stop physical activity ▪ Give rescue med (<i>name</i>): <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> other: _____ ▪ 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"/> Via spacer <input type="checkbox"/> other: _____ ▪ If student's symptoms do not improve or worsen, call 911 ▪ Stay with student and maintain sitting position ▪ Call parents/guardians and school nurse ▪ Student may resume normal activities once feeling better |

- If there is no rescue medication at school:
 - 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

RED ZONE: EMERGENCY SITUATION (Health provider complete dosing for rescue medication)

| IF YOU SEE THIS: | DO THIS IMMEDIATELY: |
|--|---|
| <ul style="list-style-type: none"> ▪ Coughs constantly ▪ Struggles or gasps for breath ▪ Trouble talking (can speak only 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness | <ul style="list-style-type: none"> ▪ Give rescue med (<i>name</i>): <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> Other: _____ ▪ Repeat rescue med if student not improving in 10-15 minutes <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> Other: _____ ▪ Call 911 Inform attendant the reason for the call is asthma ▪ Call parents/guardians and school nurse ▪ Encourage student to take slower deeper breaths ▪ Stay with student and remain calm ▪ <i>School personnel should not drive student to hospital</i> |

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 PROVIDER'S NAME _____ DATE _____

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 _____ 504 Plan or IEP

Copies of plan provided to: Teachers ___ Phys Ed/Coach ___ Principal ___ Main Office ___ Bus Driver ___ Other _____