

ASTHMA CARE PLAN AND MEDICATION ORDERS

Plan ____ of ____

Place student picture here

STUDENT NAME				Birthdate	
Grade	School	<input type="checkbox"/> Bus #	<input type="checkbox"/> Walk	<input type="checkbox"/> Drive	
<input type="checkbox"/> History of anaphylaxis		PE/Sports: Day/Time/Periods			
Brief medical history					

Asthma Triggers (check all that apply) None Known Animals Cold Air Exercise Pollens
 Respiratory illness/virus Smoke, chemicals, strong odors Other _____ (i.e., foods, emotions, insects, etc.)

Usual Asthma Symptoms (check all that apply) Cough Wheeze Shortness of breath Chest tightness
 Asking to use inhaler Other _____

Inhaler(s) location: Office Backpack On person Other _____
 Epinephrine auto-injector(s) (EAI) location Office Backpack On person Other _____

This Section to be Completed by a Licensed Healthcare Provider (LHP)

GO ZONE (GREEN) INFREQUENT/MINIMAL SYMPTOMS

- > Symptoms and/or use of quick relief medication < 2 times per week. (Does not include exercise pre-treatment usage.)
 Infrequent and minimal symptoms like cough, wheeze, and shortness of breath (if student is using the quick relief inhaler > 2 times per week or requires frequent observation by school staff → **Notify nurse and parent/guardian**)
- > Full participation in physical education and sports

CAUTION ZONE (YELLOW) SIGNIFICANT SYMPTOMS DO NOT LEAVE STUDENT UNATTENDED

- > If student is coughing, wheezing, having difficulty breathing and/or complaining of chest tightness
 Administer 2 puffs Albuterol (Pro-air®, Ventolin HFA®, Proventil®) Levalbuterol (Xopenex®)
 Use spacer/holding chamber with inhaler
 Albuterol/Levalbuterol unit dose via nebulizer
 Other _____
 May repeat in 10 minutes. → **Notify nurse and parent/guardian if repeated**
- > Until symptoms are in the GO ZONE (green), restrict strenuous physical activity
- > **If no improvement after repeated dose Call 911—See below**

STOP ZONE (RED) CALL 911 DO NOT LEAVE STUDENT UNATTENDED

If student is very short of breath, can see ribs during breathing, difficulty walking or talking, blue appearance to lips or nails, quick relief medication not working

- > **CALL 911**
- Give 4 puffs quick relief inhaler (or nebulizer treatment)
- Administer epinephrine auto-injector (EAI) 0.3 mg 0.15 mg (Jr)
- Other _____

EXERCISE PRE-TREATMENT: (check all that apply) N/A

- Give 2 puffs of quick relief inhaler 15- 30 minutes prior to PE or other strenuous exercise
- If asthma symptoms occur during exercise, follow CAUTION ZONE (YELLOW) instructions. Notify nurse and parent/guardian if occurs.

Daily Controller Medication _____ Dose _____ Time _____
 Takes daily controller medication at home Administer daily controller medication at school
SIDE EFFECTS of medication(s): increased heart rate, shakiness

This student demonstrated correct use of the rescue inhaler and EAI in the LHP's office as required Yes No
 Student can carry and self-administer rescue inhaler and EAI Needs help administering rescue inhaler and EAI

LHP Signature		LHP Print Name	
Start date	End date	<input type="checkbox"/> Last day of school	<input type="checkbox"/> Other
Date	Telephone	Fax	

Asthma Care Plan – Part 2 – Parent/Guardian

STUDENT NAME _____

EMERGENCY CONTACTS

Parent/Guardian	Name	Parent/Guardian	Name		
	Primary #		Primary #		
	Other #		Other #		
	Other #		Other #		
Name:		Relationship:		Phone:	

My child may carry and is trained to administer their rescue inhaler	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Provide extra for office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child may carry and is trained to self-administer their EAI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Provide extra for office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child may carry their rescue inhaler and/or EAI-needs assistance to administer	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

- A new care plan and medication/treatment order must be submitted each school year.
- If any changes are needed to the care plan, it is the parent/guardian's responsibility to contact the school nurse.
- It is the parent/guardian's responsibility to alert all other **non-school** programs of their child's health condition.
- Medical information may be shared with school staff working with my child and 911 staff, if they are called.
- I have reviewed the information on this care plan/504 and medication/treatment order and request/authorize trained school employees to provide this care and administer medication/treatments in accordance with the Licensed Healthcare Provider's (LHP) instructions.
- This is a life-threatening care plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's asthma between the LHP office and the school nurse.

Does the student need classroom, school activity or recess accommodations Yes No **If yes, please contact the school counselor or 504 coordinator.**

I have reviewed and agree with this health care plan/504 and medication/treatment order.

Parent/Guardian Signature _____ **Date** _____

Student (for student who self-carries/self administers rescue inhaler and/or EAI):

- I have demonstrated the correct use of the rescue inhaler and/or EAI to the medical provider and the school registered nurse.
- I agree never to share my inhaler and/or EAI with another person or use it in an unsafe manner.
- I agree that if there is no improvement after using inhaler and/or EAI, I will report to an adult.

Student Signature (Required) _____ **Date** _____

The care plan is intended to strengthen the partnership of families, healthcare providers and the school. It is based on the NHLBI Guidelines for Asthma Management.

For School District Nurse Only	504 Plan <input type="checkbox"/>
A registered nurse has completed a nursing assessment and developed this Asthma Care Plan in conjunction with the student, their parent/guardian and their LHP. Student may carry and self-administer the medication ordered above: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, has the student demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication as ordered: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Device(s) if any, used	Expiration date(s)
Registered Nurse Signature	Date