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:**
▪ Difficulty breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Unable to tolerate regular activities but still talking in complete sentences ▪ Other:	▪ Stop physical activity ▪ Give rescue med *(name)*:_____ ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ other:_____ ▪ If no improvement in 10-15 minutes, repeat use of rescue med: ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ 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:**
▪ 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	▪ Give rescue med *(name)*:_____ ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ Other:_____ ▪ Repeat rescue med if student not improving in 10-15 minutes ☐ 1 puff ☐ 2 puffs ☐ Via spacer ☐ 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 ▪ *School personnel should not drive student to hospital*

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**

_____ _____ ☐ 504 Plan or IEP
School Nurse Signature DATE

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