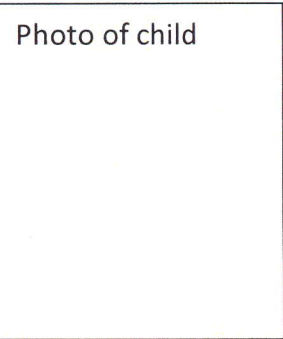


COLORADO SCHOOL ASTHMA CARE PLAN



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:

GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health provider initial all that apply)

- 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

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

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"/> other: <input type="checkbox"/> Via spacer ▪ 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 ▪ 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 inhaler 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 inhaler)

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
<ul style="list-style-type: none"> ▪ Coughs constantly ▪ Struggles or gasps for breath ▪ Trouble talking (only able to speak 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"/> Other: <input type="checkbox"/> Via spacer ▪ Repeat rescue med if student not improving in 10-15 minutes <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: <input type="checkbox"/> Via spacer ▪ 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

SCHOOL CARE PLAN FOR A STUDENT WITH ASTHMA OR BREATHING PROBLEMS

Dear Parent/Guardian: If your child has asthma or breathing problems, please complete and return this form to school. The school nurse needs more information to take care of your child at school. If you have any questions, please contact your child's school nurse.

Student Name: _____	DOB _____	Grade _____	Teacher _____
Parent/Guardian Name: _____	Phone _____		
Parent/Guardian Name: _____	Phone _____		
Other Emergency Contact Name: _____	Phone _____		
Health Care Provider for asthma: _____	Phone _____		

1. How much does your child's asthma bother or interrupt him/her during normal activities (playing, running around, and sports?)
 _____ Never _____ Rarely _____ Sometimes _____ Often _____ All of the time

2. How many times has your child been to the emergency room or hospitalized for asthma in the past year?
 _____ 0 times _____ 1 time _____ 2 times _____ 3 times _____ 4 times _____ 5 or more times

3. a) What triggers your child's asthma? (Check all that apply)

<input type="checkbox"/> Illness (colds)	<input type="checkbox"/> Smoke	Allergies: <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Dust <input type="checkbox"/> Mold <input type="checkbox"/> Pollen
<input type="checkbox"/> Emotions (crying, laughing, stress)	<input type="checkbox"/> Exercise/physical activity	<input type="checkbox"/> Food: _____
<input type="checkbox"/> Weather changes	<input type="checkbox"/> Strong odors/smells	<input type="checkbox"/> Other: _____

 b) Does your child have a life threatening allergy or anaphylaxis? Yes No
 If "yes", does s/he have an epi-pen at school? Yes No
 If "yes", complete a *Severe Allergy Plan* available from the school nurse.

4. Describe the symptoms your child typically experiences before or during an asthma episode: (Check all that apply)

<input type="checkbox"/> Coughing	<input type="checkbox"/> Rubbing chin/neck	<input type="checkbox"/> Clearing the throat
<input type="checkbox"/> Trouble breathing	<input type="checkbox"/> Breathing hard/fast	<input type="checkbox"/> Feeling tired/weak
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Runny nose	Other _____

5. Please write the names of medicines (inhalers/puffers, pills, liquids, nebulizers) your child takes for asthma and allergies daily, or on an as needed basis.

1.
2.
3.
4.

6. How well does your child take his/her asthma medications? (check only one answer)
 _____ Takes medicine by him/herself _____ Needs help taking medicine _____ Not using medicine now

7. In the past 4 weeks, how often has your child used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?
 Never Less than 2 days/week 2 or more days/wk, but not everyday Everyday

8. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?
 Never Less than 2 days/week 2 or more days/wk, but not everyday Everyday

9. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing at night while sleeping?
 Never Once Twice 3 or more times/month 2 or more times/week Every night

Parent Signature _____ Date _____