

COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS

PARENT/GUARDIAN COMPLETE AND SIGN:	School/grade: _____
Child Name: _____	Birthdate: _____
Parent/Guardian Name: _____	Phone: _____
Healthcare Provider Name: _____	Phone: _____
Triggers: <input type="checkbox"/> Weather (cold air, wind) <input type="checkbox"/> Illness <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke <input type="checkbox"/> Dust <input type="checkbox"/> Pollen <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Life threatening allergy, specify: _____	

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child/youth is experiencing symptoms. I approve this care plan for my child/youth.

PARENT SIGNATURE	DATE	NURSE/CCHC SIGNATURE	DATE
HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:		QUICK RELIEF (RESCUE) MEDICATION: <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ Common side effects: <input checked="" type="checkbox"/> heart rate, tremor <input type="checkbox"/> Have child use spacer with inhaler. Controller medication used at home: _____	
IF YOU SEE THIS:		DO THIS:	
GREEN ZONE: No Symptoms Pretreat	<ul style="list-style-type: none"> No current symptoms Doing usual activities 	Pretreat strenuous activity: <input type="checkbox"/> Not required <input type="checkbox"/> Routine <input type="checkbox"/> Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> Repeat in 4 hours, if needed for additional physical activity. <i>If child is currently experiencing symptoms, follow YELLOW ZONE.</i>	
YELLOW ZONE: Mild symptoms	<ul style="list-style-type: none"> Trouble breathing Wheezing Frequent cough Complains of tight chest Not able to do activities, but talking in complete sentences Peak flow: _____ & _____ 	<ol style="list-style-type: none"> 1. Stop physical activity. 2. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 3. Stay with child/youth and maintain sitting position. 4. REPEAT QUICK RELIEF MED, if not improving in 15 minutes: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. <i>If symptoms do not improve or worsen, follow RED ZONE.</i>	
RED ZONE: EMERGENCY Severe Symptoms	<ul style="list-style-type: none"> Coughs constantly Struggles to breathe Trouble talking (only speaks 3-5 words) Skin of chest and/or neck pull in with breathing Lips/fingernails gray or blue ↓ Level of consciousness Peak flow < _____ 	<ol style="list-style-type: none"> 1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <ul style="list-style-type: none"> ▪ Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians and school nurse. 5. If symptoms do not improve, REPEAT QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs every 5 minutes until EMS arrives. <i>School personnel should not drive student to hospital.</i> 	

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

- Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.
- Student understands proper use of asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.
- Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.

HEALTH CARE PROVIDER SIGNATURE _____ PRINT PROVIDER NAME _____ DATE _____ FAX _____ PHONE _____

Copies of plan provided to: Teacher(s) PhysEd/Coach Principal Main Office Bus Driver Other _____

