

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

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____
 School: The Episcopal Day School of Evergreen Grade: _____
 Parent/Guardian Name: _____ Phone: _____
 I approve this care plan and 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 health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), 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.

Parent/Guardian Signature _____ Date _____

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: Albuterol Other: _____
 Common side effects: heart rate, tremor Use spacer with inhaler (MDI)
Controller medication used at home: _____
TRIGGERS: Weather Illness Exercise Smoke Dust Pollen Poor Air Quality Other: _____
 Life threatening allergy specify: _____
QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.
 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 **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

	IF YOU SEE THIS:	DO THIS:
GREEN ZONE: No Symptoms Pretreat	<ul style="list-style-type: none"> No current symptoms Strenuous activity planned 	PRETREATMENT FOR STRENUOUS ACTIVITY, please choose ONE: <input type="checkbox"/> Not required OR <input type="checkbox"/> Student/Parent request OR <input type="checkbox"/> Routinely Give QUICK RELIEF MED 10-15 minutes before activity: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs Repeat in 4 hours, if needed for additional physical activity. <i>If child is currently experiencing symptoms, follow YELLOW or RED ZONE.</i>
YELLOW ZONE: Mild symptoms	<ul style="list-style-type: none"> Trouble breathing Wheezing Frequent cough Chest tightness Not able to do activities 	1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs 2. Stay with child/youth and maintain sitting position. 3. REPEAT QUICK RELIEF MED if not improving in 15 minutes: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <i>If symptoms do not improve or worsen, follow RED ZONE.</i> 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
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/blue 	1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <i>Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.</i> 2. Call 911 and inform EMS the reason for the call. 3. REPEAT QUICK RELIEF MED if not improving: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

Health Care Provider Signature _____ Print Provider Name _____ Date _____
 Good for 12 months unless specified otherwise in district policy.

Fax _____ Phone _____ Email _____

School Nurse/CCHC Signature _____ Date _____
 Self-carry contract on file. Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

