

**COLORADO SCHOOL ASTHMA CARE PLAN**

Photo of child

**PARENT/GUARDIAN complete and sign the top portion of form.**

Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
Grade:	Teacher:

**Triggers:** ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Other: \_\_\_\_\_

☐ **Life threatening allergy** : Specify \_\_\_\_\_

**If there is no quick relief inhaler at school and the student is experiencing asthma symptoms:**

- 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

**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

**HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.**

**GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.**

**Pretreatment for strenuous activity:** ☐ Not Required

**Pretreatment for strenuous activity:** ☐ Routinely **OR** ☐ Upon request Explain: (weather, viral, seasonal, other) \_\_\_\_\_  
☐ Give 2 puffs of quick relief med (Check One): ☐ Albuterol ☐ Other: \_\_\_\_\_ 10-15 minutes before activity.

☐ Repeat in 4 hours if needed for additional or ongoing physical activity.

***If student currently experiencing symptoms, follow yellow zone.***

**YELLOW ZONE: SICK – UNCONTROLLED ASTHMA**

IF YOU SEE THIS:	DO THIS:
<ul style="list-style-type: none"> <li>▪ Trouble breathing</li> <li>▪ Wheezing</li> <li>▪ Frequent cough</li> <li>▪ Complains of chest tightness</li> <li>▪ Not able to do activities but still talking in complete sentences</li> <li>▪ Peak flow between _____ and _____</li> <li>▪ Other: _____</li> </ul>	<ol style="list-style-type: none"> <li>1. Stop physical activity</li> <li>2. GIVE QUICK RELIEF MED: (Check One) <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____  <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____</li> <li>3. Call parents/guardians and school nurse.</li> <li>4. Stay with student and maintain sitting position.</li> <li>5. Student may go back to normal activities once feeling better.</li> </ol> <p><b><i>If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.</i></b></p>

**RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS**

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
<ul style="list-style-type: none"> <li>▪ Coughs constantly</li> <li>▪ Struggles to breathe</li> <li>▪ Trouble talking (only speaks 3-5 words)</li> <li>▪ Skin of chest and/or neck pull in with breathing</li> <li>▪ Lips or fingernails are gray or blue</li> <li>▪ ↓ Level of consciousness</li> <li>▪ Peak flow &lt; _____</li> </ul>	<ol style="list-style-type: none"> <li>1. GIVE QUICK RELIEF MED: (Check One): <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____  <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____  <input type="checkbox"/> Refer to anaphylaxis plan if student has life threatening allergy.</li> <li>2. Call 911 and inform EMS the reason for the call.</li> <li>3. Call parents/guardians and school nurse.</li> <li>4. Encourage student to take slow deep breaths.</li> <li>5. If symptoms continue, repeat quick relief med: <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____  <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____</li> <li>6. Stay with student and remain calm.</li> <li>7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs).</li> <li>8. <b><i>School personnel should not drive student to hospital.</i></b></li> </ol>

**INSTRUCTIONS for QUICK RELIEF INHALER USE: 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 with approval from school nurse.
- ☐ Student is to notify his/her designated school health officials after using inhaler.
- ☐ Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) \_\_\_\_\_.

\_\_\_\_\_  
HEALTH CARE PROVIDER SIGNATURE

\_\_\_\_\_  
PRINT PROVIDER'S NAME

\_\_\_\_\_  
PHONE/FAX

\_\_\_\_\_  
DATE

Copies of plan provided to: Teacher(s) \_\_\_\_\_ Phys Ed/Coach \_\_\_\_\_ Principal \_\_\_\_\_ Main Office \_\_\_\_\_ Bus Driver \_\_\_\_\_ Other \_\_\_\_\_