Photo of Child

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:_____

☐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:**
• 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** ☐ **2PUFFS** ☐ **OTHER:** ☐ **VIA SPACER** • If no improvement in 10-15 minutes, repeat use of rescue med: ☐ **1 PUFF** ☐ **2 PUFFS** ☐ **OTHER:** ☐ **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	
IF YOU SEE THIS: RED ZONE -SEVERE UNCONTROLLED ASTHMA	**DO THIS IMMEDIATELY:**
• 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	• **GIVE RESCUE MED (NAME):_____** ☐ 1 PUFF ☐2 PUFFS ☐ OTHER: ☐VIA SPACER • **Call 911 Inform attendant the reason for 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

☐Student has life threatening allergy, the EpiPen is located:_____

_____ _____ _____ _____

HEALTH CARE PROVIDER SIGNATURE PLEASE PRINT PROVIDERS NAME START DATE END DATE

Please include provider's title

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

Copy of plan provided to: ☐ Teachers ☐ Phys Ed/Coach ☐ Principal ☐ Main Office ☐Bus Driver ☐ Other ☐ 504 Plan or IEP