

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: Weather (cold air, wind) Illness Exercise Smoke Dust Pollen Other: _____
 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 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: _____ & _____ 	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 < _____ 	1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs ▪ 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)			
<input type="checkbox"/> Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler. <input type="checkbox"/> Student understands proper use of asthma medications, and in my opinion, <u>can carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.</u> <input type="checkbox"/> 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 _____



DOES YOUR CHILD HAVE ASTHMA?

■ No – STOP HERE

■ Yes – Please complete this form

If you have any questions, please contact your child's school nurse.

Date form completed: _____ Student ID _____

Student Name: _____ Birth date: _____

Parent/Guardian Name & Phone #: _____

Name of person completing form and relationship (i.e. mom, dad, grandma): _____

Health Care Provider for asthma (name & phone #): _____

1. In the past 12 months, how many times has your child visited the ER/urgent care or had an urgent doctor's office visit for asthma?
 0 times 1 times 2 times 3 times 4 times 5 or more times
2. In the past 12 months, how many times has your child been hospitalized overnight for asthma?
 0 times 1 times 2 times 3 times 4 times 5 or more times
3. In the past 12 months, how many times has your child used oral steroids (prednisone, Orapred) to treat an asthma attack?
 0 times 1 times 2 times 3 times 4 times 5 or more times
4. How many days of school did your child miss this past school year because of asthma?
 0 days 1-2 days 3-5 days 6-10 days 11-15 days 15 or more days
5. 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 1-2 days/week 3 or more days/week but not every day Every day
6. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?
 Never 1-2 days/week 3 or more days/week but not every day Every day
7. In the past 4 weeks, how often has your child awakened at night because of coughing, trouble breathing, or wheezing?
 Never 1-2 times/month 3 or more times/month 2 or more times/week Every night
8. In the past 4 weeks, how often has your child's asthma bothered or interrupted him/her during normal activities (playing, running around, and sports)?
 Never Rarely Sometimes Often All of the time
9. What triggers your child's asthma? (Check all that apply)
 Illness (colds) Smoke Allergies: Cat Dog Dust Mold Pollen
 Emotions (crying, laughing, stress) Exercise/physical activity Food: _____
 Weather changes Strong odors/smells Other: _____

10. Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) your child takes for asthma and allergies (the ones every day and as needed) and give the nurse a copy of your written asthma treatment plan.

List Names or Colors of Medicines Used for Asthma	

11. How well does your child take asthma medicines? (Only one answer)
 Takes medicine by self Needs help taking medicine Not using medicine now

Parent Signature _____ Date _____ School Nurse Reviewed _____ Date _____