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

**PARENT/GUARDIAN COMPLETE AND SIGN:**

<table>
<thead>
<tr>
<th>Child Name:</th>
<th>School/grade:</th>
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</thead>
<tbody>
<tr>
<td>Parent/Guardian Name:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Healthcare Provider Name:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Triggers:</td>
<td>□ Weather (cold air, wind) □ Illness □ Exercise □ Smoke □ Dust □ Pollen □ Other:</td>
</tr>
<tr>
<td>□ Life threatening allergy, specify:</td>
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</tbody>
</table>

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:** □ Albuterol □ Other: __________________

Common side effects: □ heart rate, tremor □ Have child use spacer with inhaler.

Controller medication used at home: __________________

**IF YOU SEE THIS:**

**DO THIS:**

**GREEN ZONE:** No Symptoms Pretreat

- No current symptoms
- Doing usual activities

PRETREAT STRENUIOUS ACTIVITY: □ Not required □ Routine □ Student/Parent request

Give QUICK RELIEF MED 10-15 minutes before activity: □ 2 puffs □ 4 puffs

Repeat in 4 hours, if needed for additional physical activity.

*If child is currently experiencing symptoms, follow YELLOW ZONE.*

**YELLOW ZONE:** Mild symptoms

- 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: □ 2 puffs □ 4 puffs
3. Stay with child/youth and maintain sitting position.
4. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: □ 2 puffs □ 4 puffs
5. Child/youth may go back to normal activities, once symptoms are relieved.

*If symptoms do not improve or worsen, follow RED ZONE.*

**RED ZONE:** Emergency Severe Symptoms

- 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: □ 2 puffs □ 4 puffs
   - Refer to anaphylaxis plan, if child/youth has life-threatening allergy.
2. Call 911 and inform EMS the reason for the call.
4. Notify parents/guardians and school nurse.
5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: □ 2 puffs □ 4 puffs
   every 5 minutes until EMS arrives.

*School personnel should not drive student to hospital.*

**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.

**HEALTHCARE PROVIDER SIGNATURE**

**PRINT PROVIDER NAME**

**DATE**

**FAX**

**PHONE**

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

Revised: March 2018