

**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
<b>HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:</b>			QUICK RELIEF (RESCUE) MEDICATION: <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ Common side effects: <input checked="" type="checkbox"/> heart rate, tremor <input type="checkbox"/> Have child use spacer with inhaler. Controller medication used at home: _____		
<b>IF YOU SEE THIS:</b>			<b>DO THIS:</b>		
<b>GREEN ZONE:</b> No Symptoms Pretreat	<ul style="list-style-type: none"> <li>No current symptoms</li> <li>Doing usual activities</li> </ul>		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. <b><i>If child is currently experiencing symptoms, follow YELLOW ZONE.</i></b>		
<b>YELLOW ZONE:</b> Mild symptoms	<ul style="list-style-type: none"> <li>Trouble breathing</li> <li>Wheezing</li> <li>Frequent cough</li> <li>Complains of tight chest</li> <li>Not able to do activities, but talking in complete sentences</li> <li>Peak flow: _____ &amp; _____</li> </ul>		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. <b>REPEAT</b> 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. <b><i>If symptoms do not improve or worsen, follow RED ZONE.</i></b>		
<b>RED ZONE: EMERGENCY</b> Severe Symptoms	<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/fingernails gray or blue</li> <li>↓ Level of consciousness</li> <li>Peak flow &lt; _____</li> </ul>		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, <b>REPEAT</b> QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs every 5 minutes until EMS arrives. <b><i>School personnel should not drive student to hospital.</i></b>		

**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.

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 \_\_\_\_\_

