COLORADO STATE ASTHMA CARE PLAN

Photo of child

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 inhaler 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 inhaler *(name)*: ☐ 1 puff ☐ 2 puffs ☐ other: ☐ Via spacer ▪ If no improvement in 10-15 minutes, repeat use of rescue inhaler: ☐ 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 within 20 minutes, 911 will be called

IF YOU SEE THIS:	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 inhaler *(name)* : ☐ 1 puff ☐ 2 puffs ☐ Other: ☐ Via spacer ▪ Repeat rescue inhaler if student not improving in 10-15 minutes ☐ 1 puff ☐ 2 puffs ☐ Other: ☐ Via spacer ▪ Call 911 Inform attendant the reason for the 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(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
☐ Student is to notify his/her designated school health officials after using inhaler
☐ Student needs supervision or assistance to use his/her inhaler If not self carry, the inhaler is located:
☐ Student has life threatening allergy, the epipen is located:

_____ _____
HEALTH CARE PROVIDER SIGNATURE PLEASE PRINT PROVIDER'S NAME DATE

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

☐ 504 Plan or IEP

_____ _____
School Nurse Signature DATE

Copies of plan provided to: ☐ Teachers ☐ Phys Ed/Coach ☐ Principal ☐ Main Office ☐ Bus Driver ☐ Other

Cherry Creek School District #5 School: _____

Fax #: _____

PERMISSION TO GIVE PRESCRIPTION/HOMEOPATHIC MEDICATION AT SCHOOL

The school nurse is required by Colorado State Law to have this form signed by the parents and the Health Care Provider of a student before prescription medication can be administered at school. For safety reasons, parents are requested to bring the medication directly to the nurse. If medication cannot be delivered to the clinic by the parent/guardian, please contact the health clinic to make other arrangements. Prescription meds must be in a pharmacy-labeled container that includes the child's name, medication, dosage, the prescriber's name and directions for administration. Some homeopathic preparations may require a review from the Cherry Creek School District Medical Advisory Board. New forms must be completed with any changes in medication, dose or time to be given. The parent agrees to pick up expired or unused medication within one week of notification or it will be destroyed.

To be completed by Licensed Health Care Provider with prescriptive authority:

Student's Name: _____ Date of Birth: _____

Medication: _____

Dosage: _____ Route: _____

To be given at the following time(s): _____

Special Instructions: _____

Purpose of medication: _____

Side effects that need to be reported: _____,

including any adverse reaction.

Starting Date: _____ Ending Date: _____

_____ _____

(Signature of Health Care Provider with Prescriptive Authority) (License Number)

_____ _____ _____

(Print name of Health Care Provider with Prescriptive Authority) (Phone) (Fax)

ATTENTION PRESCRIBERS: IF THIS Rx IS FOR A RESCUE INHALER OR EPI-PEN:

☐ This student has been instructed by the healthcare provider in the proper use of this medication and is capable of carrying and self-administering this medication. _____

(Signature of Health Care Provider)

By signing this document, I give permission for the nurse or nurse designee to administer the medication as prescribed. Should the nurse have any concerns about this order, I give my permission for this Health Care Provider to share information about this medication's administration with the Registered Nurse.

_____ _____ _____

(Parent/Guardian Signature) (Phone) (Date)

This consent must be resubmitted at the beginning of every school year.

RV 04-10

CLINIC FAX: 720.747.3185