

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

**PARENT/GUARDIAN COMPLETE, SIGN AND DATE:**

Child Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 School: \_\_\_\_\_ Grade: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I approve this care plan and 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 health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), 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.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:**

**QUICK RELIEF MEDICATION:**  Albuterol  Other: \_\_\_\_\_  
 Common side effects:  heart rate, tremor  Use spacer with inhaler (MDI)  
**Controller medication used at home:** \_\_\_\_\_  
**TRIGGERS:**  Weather  Illness  Exercise  Smoke  Dust  Pollen  Poor Air Quality  Other: \_\_\_\_\_  
 Life threatening allergy specify: \_\_\_\_\_  
**QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.**  
 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 **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

	<b>IF YOU SEE THIS:</b>	<b>DO THIS:</b>
<b>GREEN ZONE: No Symptoms Pretreat</b>	<ul style="list-style-type: none"> <li>No current symptoms</li> <li>Strenuous activity planned</li> </ul>	<p><b>PRETREATMENT FOR STRENUOUS ACTIVITY</b>, please choose <b>ONE</b>:</p> <input type="checkbox"/> Not required <b>OR</b> <input type="checkbox"/> Student/Parent request <b>OR</b> <input type="checkbox"/> Routinely Give <b>QUICK RELIEF MED</b> 10-15 minutes before activity: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs Repeat in 4 hours, if needed for additional physical activity. <i><b>If child is currently experiencing symptoms, follow YELLOW or RED ZONE.</b></i>
<b>YELLOW ZONE: Mild symptoms</b>	<ul style="list-style-type: none"> <li>Trouble breathing</li> <li>Wheezing</li> <li>Frequent cough</li> <li>Chest tightness</li> <li>Not able to do activities</li> </ul>	<ol style="list-style-type: none"> <li>Give <b>QUICK RELIEF MED</b>: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs</li> <li>Stay with child/youth and maintain sitting position.</li> <li><b>REPEAT QUICK RELIEF MED</b> if not improving in 15 minutes: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs  <i><b>If symptoms do not improve or worsen, follow RED ZONE.</b></i></li> <li>Child/youth may go back to normal activities, once symptoms are relieved.</li> <li>Notify parents/guardians and school nurse.</li> </ol>
<b>RED ZONE: EMERGENCY Severe Symptoms</b>	<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/blue</li> </ul>	<ol style="list-style-type: none"> <li>Give <b>QUICK RELIEF MED</b>: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs  <i><b>Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.</b></i></li> <li>Call 911 and inform EMS the reason for the call.</li> <li><b>REPEAT QUICK RELIEF MED</b> if not improving: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs                      Can repeat every 5-15 minutes until EMS arrives.</li> <li>Stay with child/youth. Remain calm, encouraging slower, deeper breaths.</li> <li>Notify parents/guardians and school nurse.</li> </ol>

Health Care Provider Signature \_\_\_\_\_ Print Provider Name \_\_\_\_\_ Date \_\_\_\_\_  
 Good for 12 months unless specified otherwise in district policy.

Fax \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

School Nurse/CCHC Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Self-carry contract on file.  Anaphylaxis plan on file for life threatening allergy to:

\*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

