

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

PARENT/GUARDIAN COMPLETE AND SIGN:

Child Name: _____ School/grade: _____
 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 			
YELLOW ZONE: Mild symptoms	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>			
RED ZONE: EMERGENCY Severe 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: _____ & _____ 			
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 < _____ 			
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 _____

