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
_____	_____	_____	_____

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 strenuous 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. 6. Notify parents/guardians and school nurse. ***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. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 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.

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_____

Asthma Intake Form

DOES YOUR CHILD HAVE ASTHMA?

- **No** – STOP HERE
- **Yes** – Please complete this form

If you have any questions, please contact your child's school nurse.

Date form completed:_____ Student ID_____

Student Name: _____Birth date:_____

Parent/Guardian Name & Phone #:_____

Name of person completing form and relationship (i.e. mom, dad, grandma):_____

Health Care Provider for asthma (name & phone #):_____

1. In the past 12 months, how many times has your child visited the ER/urgent care or had an urgent doctor's office visit for asthma?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

2. In the past 12 months, how many times has your child been hospitalized overnight for asthma?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

3. In the past 12 months, how many times has your child used oral steroids (prednisone, Orapred) to treat an asthma attack?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

4. How many days of school did your child miss this past school year because of asthma?
   ☐ 0 days ☐ 1-2 days ☐ 3-5 days ☐ 6-10 days ☐ 11-15 days ☐ 16 or more days

5. In the past 4 weeks, how often has your child used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?
   ☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not every day ☐ Every day

6. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?
   ☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not every day ☐ Every day

7. In the past 4 weeks, how often has your child awakened at night because of coughing, trouble breathing, or wheezing?
   ☐ Never ☐ 1-2 times/month ☐ 3 or more times/month ☐ 2 or more times/week ☐ Every night

8. In the past 4 weeks, how often has your child's asthma bothered or interrupted him/her during normal activities (playing, running around, and sports)?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ All of the time

9. What triggers your child's asthma? (Check all that apply)
   ☐ Illness (colds) ☐ Smoke Allergies: ☐Cat ☐Dog ☐Dust ☐Mold ☐Pollen
   ☐ Emotions (crying, laughing, stress) ☐ Exercise/physical activity ☐Food: _____
   ☐ Weather changes ☐ Strong odors/smells Other:_____

10. Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) your child takes for asthma and allergies (the ones every day and as needed) and give the nurse a copy of your written asthma treatment plan.

List Names or Colors of Medicines Used for Asthma	

11. How well does your child take asthma medicines? (Only one answer)
    ☐Takes medicine by self ☐Needs help taking medicine ☐Not using medicine now

Parent Signature_____Date_____School Nurse Reviewed_____Date_____

Asthma Self Carry Contract

In accordance with the "Colorado Schoolchildren's Asthma and Anaphylaxis Health Management Act" this student has permission to carry and self-administer their asthma medication for the current school year.
https://www.cde.state.co.us/sites/default/files/documents/healthandwellness/download/coloradoschoolchildren.pdf

School/Child Care: _____ School Year/Date: _____

STUDENT/CHILD: _____ Birthdate: _____ Grade/Classroom: _____

☐ I will keep my rescue inhaler with me at school/child care and will follow my doctor's instructions.
☐ I will use my rescue inhaler safely at school/child care and any school/child care sponsored events.
☐ If I have asthma difficulty I will tell school/child care staff or I will go to the school health office.
☐ I will not allow any other person to use my inhaler.
☐ If I don't use my medicine safely, I may lose my privilege.

Student's Signature _____Date _____

PARENT/GUARDIAN: _____

This contract is in effect for the current school year unless revoked by the provider or student fails to meet the above safety contingencies.

☐ I agree to make sure that my child carries his/her asthma medication.
☐ I will see my child carries the prescribed medication. The device will contain medication, the medication won't be expired and the medication will have my child's name on it.
☐ I have been told to keep an extra rescue inhaler in the Health Office or _____.
☐ I know school/child care staff may review this contract with me if my child doesn't follow doctor orders or doesn't follow agreement.
☐ I will provide a doctor signed medication authorization to the school.

Parent's Signature _____Date _____

Child Care Health Consultant/School Nurse: _____

☐ The above child has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pre-treatment with an inhaler prior to exercise.
☐ I have notified the appropriate staff that need to know of the child's health condition and have advised them of the child's authorization to carry and self-administer their asthma medication.
☐ I have verified that all appropriate paperwork has been completed and the school nurse/child care health consultant has determined that this child has the skill level necessary to carry and self-administer their asthma medication at school/child carl and school/child care sponsored activities.

Child Care Health Consultant/School Nurse signature _____Date _____