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.

IF YOU SEE THIS:		DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Strenuous activity planned	**PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**: ☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely 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 or RED ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs 2. Stay with child/youth and maintain sitting position. 3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs ***If symptoms do not improve or worsen, follow RED ZONE.*** 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
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/blue	1. Give **QUICK RELIEF MED**: ☐ 2 puffs ☐ 4 puffs ***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.*** 2. Call 911 and inform EMS the reason for the call. 3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

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.

Revised: February 2021

Asthma Self Carry Contract **The Vanguard School Year: _____Grade: _____**

STUDENT :_____ DOB:_____

- ☐ I plan to keep my rescue inhaler with me at school rather than in the school health office.
- ☐ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.
- ☐ I will notify the school health office if I am having more difficulty than usual with my asthma.
- ☐ I will not allow any other person to use my inhaler.

Student's Signature _____Date _____

PARENT/GUARDIAN:_____

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

- ☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.
- ☐ It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.
- ☐ I will review the status of the student's asthma with the student on a regular basis as agreed in the health care plan.
- ☐ I will provide the school a Health Care Provider signed medication authorization for this medication.

Parent's Signature _____Date _____

School Nurse/RN or Nurse Consultant: The Vanguard School

- ☐ The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.
- ☐ School staff that have the need to know about the student's condition and the need to carry medication have been notified.
- ☐ I will review the medication authorization provided by the parent and signed by the health care provider.

RN/Nurse's Signature: _____ Date: _____
Teacher's Signature: _____ Date: _____
Health Assistant Signature: _____ Date: _____
School Administrator's Signature: _____ Date: _____