

Asthma Care Plan & Medication Orders

Student Name: _____ DOB: _____ Teacher: _____ Grade: _____

Parent/Guardian: _____ Phone: (C) _____ (W) _____ (H) _____

HEALTH CARE PROVIDER TO COMPLETE ALL SECTIONS BELOW

Quick Relief Medication:	Triggers:
<input type="checkbox"/> <u>ALBUTEROL</u> <input type="checkbox"/> Other: _____	<input type="checkbox"/> Weather <input type="checkbox"/> Illness <input type="checkbox"/> Exercise <input type="checkbox"/> Smoke <input type="checkbox"/> Dog/Cat <input type="checkbox"/> Mold <input type="checkbox"/> Pollen <input type="checkbox"/> Other: _____
GREEN ZONE: PRETREATMENT STEPS	
<input type="checkbox"/> Give 2 puffs of quick relief medication 15 minutes before activity.	
For use in: <input type="checkbox"/> P.E. Class <input type="checkbox"/> Exercise/Sports <input type="checkbox"/> Recess <input type="checkbox"/> Illness <input type="checkbox"/> Repeat in 4 hours if needed for additional or ongoing physical activity	
YELLOW ZONE: SICK/UNCONTROLLED ASTHMA	
If you see this:	Do this:
<ul style="list-style-type: none"> • Difficulty breathing • Wheezing • Frequent cough • Complains of chest tightness • Unable to tolerate regular activities but still talking in complete sentences • Other: _____ 	<ol style="list-style-type: none"> 1. Stop physical activity 2. Give quick relief medication <input type="checkbox"/> 2 puffs every 4 hours PRN <input type="checkbox"/> Via spacer <input type="checkbox"/> With Mask <input type="checkbox"/> Other: _____ 3. If no improvement in 10-15 minutes, repeat use of quick relief medication <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> With Mask <input type="checkbox"/> Other: _____ 4. If student's symptoms do not improve or worsen, call Site Nurse 5. Stay with student and maintain sitting position 6. Call parents/guardians 7. Student may resume normal activities once feeling better
If there is no quick relief inhaler at school: <ol style="list-style-type: none"> a. Call parents/guardians to pick up student and/or bring inhaler/medications to school b. Inform parents/guardians that if they cannot get to school, 911 may be called 	
RED ZONE: EMERGENCY SITUATION	
If you see this:	Do this:
<ul style="list-style-type: none"> • Coughs constantly • Struggles or gasps for breath • Trouble talking <ul style="list-style-type: none"> o can speak only 3-5 words • Skin of chest and/or neck pull in breathing • Lips or fingernails are gray or blue • Lowered level of consciousness 	<ol style="list-style-type: none"> 1. Give quick relief medication <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> With Mask <input type="checkbox"/> Other: _____ 2. If no improvement in 5-10 minutes, repeat use of quick relief medication <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> With Mask <input type="checkbox"/> Other: _____ <input type="checkbox"/> Refer to anaphylaxis plan if student has life threatening allergy 3. If directed by nurse, or unable to reach nurse in a timely manner, call 911 – inform dispatcher the reason for the call is asthma. 4. Stay with student and remain calm 5. Encourage student to take slower deeper breaths <p><i>*Note: School personnel should not drive student to hospital</i></p>
Health Care Provider Information:	
Signature: _____ Date: _____ Name (print): _____ Address: _____ Phone: _____ Fax: _____	
<input type="checkbox"/> Student needs supervision or assistance to use his/her inhaler <input type="checkbox"/> Student has life threatening allergy, refer to anaphylaxis plan <input type="checkbox"/> Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently.	

I, as the parent/guardian, request that the above medication(s) be made available to my child at the times prescribed. I authorize the District Nurse/other designated school personnel to contact my child's physician and pharmacist regarding this recommendation. I will provide all medication(s) in the prescription container(s) which is labeled with my child's name, the prescribing physician's name, the dosage, times to be given and monitoring devices (if needed). I will notify the District Nurse/other designated school personnel, if there is a change to my student's medication, health status or authorized health care provider. I approve this Asthma Care Plan/Medication Orders for my child.

Parent Signature: _____ Date: _____ District Nurse Signature: _____ Date: _____