COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

PARENT/GUARDIAN complete and sign the top portion of form.	
Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
Grade:	Teacher:

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Other: _____

☐ **Life threatening allergy :** Specify _____

If there is no quick relief inhaler at school and the student is experiencing asthma symptoms:

- Call parents/guardians to pick up student and/or bring inhaler/ medications to school
- Inform them that if they cannot get to school, 911 may be called

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ _____ _____ _____ ☐ 504 PLAN OR IEP

PARENT SIGNATURE | DATE | SCHOOL NURSE SIGNATURE | DATE

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: ☐ Not Required

Pretreatment for strenuous activity: ☐ Routinely **OR** ☐ Upon request Explain: (weather, viral, seasonal, other) _____

☐ Give 2 puffs of quick relief med (Check One): ☐ Albuterol ☐ Other: _____ 10-15 minutes before activity.

☐ Repeat in 4 hours if needed for additional or ongoing physical activity.

If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	DO THIS:
▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between _____ and _____ ▪ Other: _____	1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. ***If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.***

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < _____	1. GIVE QUICK RELIEF MED: (Check One): ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ ☐ Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: ☐ Albuterol ☐ Other: _____ ☐ 2 puffs ☐ Other: _____ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs). 8. *School personnel should not drive student to hospital.*

INSTRUCTIONS for QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse.

☐ Student is to notify his/her designated school health officials after using inhaler.

☐ Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) _____.

_____ _____ _____ _____

HEALTH CARE PROVIDER SIGNATURE | PRINT PROVIDER'S NAME | PHONE/FAX | DATE

Copies of plan provided to: Teacher(s) ___ Phys Ed/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 Intake Form

¿SU HIJO PADECE DE ASMA?

☐ **No – NO DEBE LLENAR ESTE FORMULARIO**

☐ **Sí** – Debe llenar este formulario

Si tiene alguna pregunta, póngase en contacto con la enfermera de la escuela de su hijo.

Fecha en que llena el formulario:_____ N.º de ID del estudiante:_____

Nombre del estudiante: _____ Fecha de nacimiento:_____

Nombre del padre o tutor legal y n.º de teléfono:_____

Nombre de la persona que llena el formulario y parentesco (p.ej. mamá, papá, abuela):_____

Médico tratante del asma (nombre y n.º de teléfono):_____

1. ¿Cuantas veces en los <u>últimos 12 meses</u> ha ido su hijo a una sala de emergencia /de cuidados urgentes o al médico debido al asma?
   ☐ 0 veces ☐ 1 vez ☐ 2 veces ☐ 3 veces ☐ 4 veces ☐ 5 veces o más

2. ¿Cuántas veces en los <u>últimos 12 meses</u> ha sido hospitalizado su hijo por causa del asma?
   ☐ 0 veces ☐ 1 vez ☐ 2 veces ☐ 3 veces ☐ 4 veces ☐ 5 veces o más

3. ¿Cuántas veces en los <u>últimos 12 meses</u> ha usado su hijo corticoesteroides orales (prednisona, Orapred) para tratar una crisis asmática?
   ☐ 0 veces ☐ 1 vez ☐ 2 veces ☐ 3 veces ☐ 4 veces ☐ 5 veces o más

4. ¿Cuántos días faltó a clases su hijo en los <u>últimos 12 meses</u> debido al asma?
   ☐ 0 días ☐ 1-2 días ☐ 3-5 días ☐ 6-10 días ☐ 11-15 días ☐ 16 o más días

5. ¿Con qué frecuencia ha usado su hijo una medicina de rescate o de alivio (un jarabe, inhalador o máquina para respirar) en las últimas 4 semanas para aliviar la tos, problemas respiratorios o sibilancias?
   ☐ Nunca ☐ 1-2 días a la semana ☐ 3 o más días a la semana pero no todos los días ☐ Todos los días

6. ¿En las <u>últimas 4 semanas,</u> con cuánta frecuencia ha tenido su hijo tos, problemas respiratorios o sibilancias en la <u>mañana o durante el día?</u>
   ☐ Nunca ☐ 1-2 días a la semana ☐ 3 o más días a la semana pero no todos los días ☐ Todos los días

7. ¿En las <u>últimas 4 semanas,</u> con cuánta frecuencia su hijo <u>se ha despertado en la noche</u> por causa de la tos, problemas respiratorios o sibilancias?
   ☐ Nunca ☐ 1-2 veces al mes ☐ 3 o más veces al mes ☐ 2 o más veces a la semana ☐ Todas las noches

8. ¿Con qué frecuencia el asma de su hijo ha sido una molestia o ha interrumpido sus actividades normales (jugar, correr y deportes) <u>en las últimas 4 semanas</u>?
   ☐ Nunca ☐ Rara vez ☐ Algunas veces ☐ Con frecuencia ☐ Todo el tiempo

9. ¿Qué provoca el asma de su hijo? (Marque todas las que correspondan)
   ☐ Enfermedad (resfriados) ☐ Humo Alergias: ☐ Gato ☐ Perro ☐ Polvo ☐ Moho ☐ Polen
   ☐ Emociones (llorar, reír, estrés) ☐ Ejercicio/actividad física ☐ Alimentos: _____
   ☐ Cambios de tiempo ☐ Olores fuertes Otro:_____

10. Escriba los nombres o colores de las medicinas (inhaladores, pastillas, líquidos, nebulizadores) que su hijo toma para el asma y las alergias (las que usa a diario y según sea necesario) y entregue a la enfermera una copia de su plan escrito para el tratamiento del asma.

Liste los nombres o colores de las medicinas usadas para el asma	

11. ¿Cómo toma su hijo las medicinas para el asma? (Solo una respuesta)
    ☐ Toma la medicina solo ☐ Necesita ayuda para tomar la medicina ☐ En este momento, no toma medicinas

Firma del padre _____Fecha_____Revisado por la enfermera escolar_____Fecha _____

CONTRACT FOR STUDENTS CARRYING INHALERS WITH THEM WHILE AT SCHOOL

This contract is in effect for the current school year unless revoked by the healthcare provider or if the student fails to meet the expectations agreed upon.

STUDENT

☐ 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, and according to my doctor's orders.

☐ I will notify the school health office, or my parents, if I am having more difficulty than usual with my breathing.

☐ I will not allow any other person to use my inhaler.

Student Signature _____ Date _____

PARENT/GUARDIAN

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and that the medication has not expired.

☐ It has been recommended to me that a back-up rescue inhaler also be provided to the school health office for emergencies.

☐ I will review the status of my child's asthma on a regular basis as agreed upon in the treatment plan.

Parent Signature _____ Date _____

SCHOOL NURSE

☐ The student has demonstrated correct technique for inhaler use, an understanding of the prescribed time and dosage, and an understanding of the concept of pre-treating with an inhaler prior to exercise.

☐ School staff who have the need to know about the student's condition and the need to carry medication have been notified.

School Nurse Signature _____ Date _____