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

## PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: Holy Apostles Preschool 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<br>• Strenuous activity planned | **PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**:<br>☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely<br>Give **QUICK RELIEF MED** 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs<br>Repeat in 4 hours, if needed for additional physical activity.<br>***If child is currently experiencing symptoms, follow YELLOW or RED ZONE.*** |
| **YELLOW ZONE: Mild symptoms** | • Trouble breathing<br>• Wheezing<br>• Frequent cough<br>• Chest tightness<br>• Not able to do activities | 1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs<br>2. Stay with child/youth and maintain sitting position.<br>3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs<br>***If symptoms do not improve or worsen, follow RED ZONE.***<br>4. Child/youth may go back to normal activities, once symptoms are relieved.<br>5. Notify parents/guardians and school nurse. |
| **RED ZONE: EMERGENCY Severe Symptoms** | • Coughs constantly<br>• Struggles to breathe<br>• Trouble talking (only speaks 3-5 words)<br>• Skin of chest and/or neck pull in with breathing<br>• Lips/fingernails gray/blue | 1. Give **QUICK RELIEF MED**: ☐ 2 puffs ☐ 4 puffs<br>***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.***<br>2. Call 911 and inform EMS the reason for the call.<br>3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs<br>Can repeat every 5-15 minutes until EMS arrives.<br>4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths.<br>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