Fountain • Fort Carson
SCHOOL DISTRICT EIGHT

COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

Name:	Birth date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
Home Phone:	Work Phone:
Other Contact:	Phone:
Preferred Hospital:	

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dog/Cat ☐ Dust ☐ Mold ☐ Pollen
Other:

GREEN ZONE: **PRETREATMENT STEPS FOR EXERCISE** (Health provider initial all that apply)

☐ Give 2 puffs of rescue med 15 minutes before activity (Circle indication: Phys Ed class, exercise/sports, recess). Explanation:
☐ Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: **SICK – UNCONTROLLED ASTHMA** (Health provider complete dosing for rescue inhaler)

IF YOU SEE THIS:	**DO THIS:**
▪ Difficulty breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Unable to tolerate regular activities but still talking in complete sentences ▪ Other:	▪ Stop physical activity ▪ Give rescue med *(name)*: ☐1 puff ☐2 puffs ☐Other: ☐Via spacer ▪ If no improvement in 10-15 minutes, repeat use of rescue med: ☐1 puff ☐2 puffs ☐Other: ☐Via spacer ▪ If student's symptoms do not improve or worsen, call 911 ▪ Stay with student and maintain sitting position ▪ Call parents/guardians and school nurse ▪ Student may resume normal activities once feeling better

▪ If there is **no rescue inhaler at school**:
  ➢ 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

RED ZONE: **EMERGENCY SITUATION** (Health provider complete dosing for rescue inhaler)

IF YOU SEE THIS:	**DO THIS IMMEDIATELY:**
▪ Coughs constantly ▪ Struggles or gasps for breath ▪ Trouble talking (only able to speak 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness	▪ Give rescue med *(name)* :_____ ☐1 puff ☐2 puffs ☐Other: ☐Via spacer ▪ Repeat rescue med if student not improving in 10-15 minutes ☐1 puff ☐2 puffs ☐Other: ☐Via spacer ▪ Call 911 – Inform attendant the reason for the call is asthma ▪ Call parents/guardians and school nurse ▪ Encourage student to take slower deeper breaths ▪ Stay with student and remain calm ▪ *School personnel should not drive student to hospital*

INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE 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
Student is to notify his/her designated school health officials after using inhaler
Student needs supervision or assistance to use his/her inhaler. If not self carry, the inhaler is located:
Student has life threatening allergy, the epipen is located:

HEALTH CARE PROVIDER SIGNATURE PLEASE PRINT PROVIDER'S NAME DATE

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.

PARENT SIGNATURE DATE

504 Plan or IEP

School Nurse Signature DATE

Copies of plan provided to: Teachers ☑ Phys Ed/Coach ☐ Principal ☐ Main Office ☐ Bus Driver ☐ Other: