



Student Services

# Health Care Action Plan – Asthma

Please return form to: School: \_\_\_\_\_ Fax: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Symptoms and History of Asthma Attacks

## Medications available at school for treatment

## School accommodations and treatments

**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

\_\_\_\_\_  504 Plan or IEP  
 School Nurse Signature DATE

Copies of plan provided to:  Teachers

