

ASTHMA CARE PLAN AND MEDICATION ORDERS

Plan ____ of ____

Place
student
picture
here

STUDENT NAME

Birthdate

Grade

School

☐ Bus #

☐ Walk

☐ Drive

Weight:

Height:

☐ History of anaphylaxis

Brief medical history:

Asthma Triggers (check all that apply) ☐ None Known ☐ Animals ☐ Cold Air ☐ Exercise ☐ Pollens

☐ Respiratory illness/virus ☐ Smoke, chemicals, strong odors ☐ Other _____ (i.e., foods, emotions, insects, etc.)

Usual Asthma Symptoms (check all that apply) ☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness

☐ Asking to use inhaler ☐ Other _____

Inhaler(s) location: ☐ Office ☐ Backpack ☐ On person ☐ Other _____

Epinephrine auto-injector(s) (EAI) location ☐ Office ☐ Backpack ☐ On person ☐ Other _____

This Section to be Completed by a Licensed Healthcare Provider (LHP)

GO ZONE (GREEN)

INFREQUENT/MINIMAL SYMPTOMS

Symptoms and/or use of quick relief medication < 2 times per week. (Does not include exercise pre-treatment usage.) Infrequent and minimal symptoms like cough, wheeze, and shortness of breath. Full participation in physical education and sports is allowed.

If student is using the quick relief inhaler > 2 times per week or requires frequent observation by school staff
→ **Notify school nurse-phone # _____ and parent/guardian.**

GREEN ZONE
Peak Flow Range
_____ to _____
☐ N/A Peak Flow

CAUTION ZONE (YELLOW) SIGNIFICANT SYMPTOMS DO NOT LEAVE STUDENT UNATTENDED

SYMPTOMS INCREASE: Cough, wheeze, chest tightness, or shortness of breath, can do some, but not all, usual activities

ADMINISTER ☐ **Quick-relief Medication:** _____ **Number of puffs:** _____
☐ **Use spacer/chamber with inhaler**

OR ☐ **Quick-relief Medication via Nebulizer:** _____ **Dosage:** _____

Can repeat every _____ minutes up to maximum of _____ doses

- If symptoms (and peak flow, if used) resolve student returns to GREEN ZONE guidance
- If symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

Administer ☐ **Quick-relief Medication:** _____ **Number of puffs:** _____

OR ☐ **Nebulizer (2nd dose)**

Contact school nurse (if available) and parent/guardian. Student should not remain at school at this point.
Continue to stay with and monitor the student until parent/guardian arrives.

YELLOW ZONE
Peak Flow Range
_____ to _____

EMERGENCY ZONE (RED) EXTREME SYMPTOMS DO NOT LEAVE STUDENT UNATTENDED

If student is very short of breath, can see ribs during breathing, difficulty walking or talking, blue appearance to lips or nails, quick relief medication not working

- **CALL 911** ☐ Give 4 puffs quick relief inhaler (or nebulizer treatment)
☐ Administer epinephrine auto-injector (EAI) ☐ 0.3 mg ☐ 0.15 mg (Jr)
☐ Other _____

Contact school nurse (if available) and parent/guardian. Adult stays with student

RED ZONE
Peak Flow Range
Below: _____

EXERCISE PRE-TREATMENT: ☐ N/A PE/Sports: Day/Time/Periods _____

☐ Give 2 puffs of quick relief inhaler 15- 30 minutes prior to PE or other strenuous exercise

If asthma symptoms occur during exercise, follow CAUTION ZONE (YELLOW) instructions. Notify nurse and parent/guardian if occurs.

Daily Controller Medication _____ **Dose** _____ **Time** _____

☐ Takes daily controller medication at home ☐ Administer daily controller medication at school

SIDE EFFECTS of medication(s): increased heart rate, shakiness

This student demonstrated correct use of the rescue inhaler and EAI in the LHP's office as required ☐ Yes ☐ No

☐ Student can carry and self-administer rescue inhaler and EAI ☐ Needs help administering rescue inhaler and EAI

LHP Signature

LHP Print Name

Start date

End date ☐ Last day of school ☐ Other

Date

Telephone

Fax

Asthma Care Plan – Part 2 – Parent/Guardian

STUDENT NAME _____

EMERGENCY CONTACTS

Parent/Guardian	Name	Parent/Guardian	Name
	Primary #		Primary #
	Other #		Other #
	Other #		Other #
Other Emergency Contact:		Relationship:	Phone:

My child may carry and is trained to administer their rescue inhaler ☐ Yes ☐ No Provide extra for office ☐ Yes ☐ No
My child may carry and is trained to self-administer their EAI (epi pen) ☐ Yes ☐ No Provide extra for office ☐ Yes ☐ No
My child needs to carry their rescue inhaler and/or EAI- and will need assistance with administration ☐ Yes ☐ No

- A new care plan and medication/treatment order must be submitted each school year.
- If any changes are needed to the care plan, it is the parent/guardian's responsibility to contact the school nurse.
- It is the parent/guardian's responsibility to alert all other **non-school** programs of their child's health condition.
- I understand that the school district cannot be held responsible for negative outcomes resulting from my child self-administering their medication at my request.
- Medical information may be shared with school staff working with my child and 911 staff, if they are called.
- This is a life-threatening care plan and can only be discontinued by the LHP.
- I authorize the exchange of information about my child's asthma between the LHP office and the school nurse.

My child needs classroom, school activity or recess accommodations ☐ Yes ☐ No

If yes, please contact the school counselor or 504 coordinator.

I have reviewed the information on this care plan/504 and medication/treatment order and request/authorize trained school employees to provide this care and administer medication/treatments in accordance with the Licensed Healthcare Provider's (LHP) instructions.

Parent/Guardian Signature _____

Date _____

Student (for all students but required for student who self-carries/self-administers rescue inhaler and/or EAI):

- I have demonstrated the correct use of the rescue inhaler and/or EAI to the medical provider and the school registered nurse.
- I agree never to share my inhaler and/or EAI with another person or use it in an unsafe manner.
- I agree that if there is no improvement after using inhaler and/or EAI, I will report to an adult.

Student Signature (Required) _____

Date _____

- **The care plan is intended to strengthen the partnership of families, healthcare providers and the school. It is based on the NHLBI Guidelines for Asthma Management.**
- Some students are capable of carrying and using their quick relief inhaler by themselves. The student, student's parents, school nurse and health care provider will collectively make this decision. The school nurse must also evaluate technique for effective use.

For School District Nurse Only

504 Plan ☐

A registered nurse has completed a nursing assessment and developed this Asthma Care Plan in conjunction with the student, their parent/guardian and their LHP.

Student may carry and self-administer the medication ordered above: ☐ Yes ☐ No

If yes, has the student demonstrated to the registered nurse, the skill necessary to use the medication and any device necessary to administer the medication as ordered: ☐ Yes ☐ No

Device(s) if any, used _____

Expiration date(s) _____

Registered Nurse Signature: _____

Date: _____

Phone number: _____

The following form will assist the school nurse and staff in determining any special needs for your child and the development of an individualized healthcare plan (IHP). This form is to be completed at initial IHP development and every 2 years thereafter. If you desire a conference with the school nurse, please call your child's school for an appointment.

1. Does your child have a diagnosis of asthma from a healthcare provider: ☐ No ☐ Yes

Managing physician: _____ Phone: _____

2. History of Current Status:

- a) What are your child's triggers:

☐ Exercise ☐ Foods: _____ ☐ Vapors _____ ☐ Pollen
☐ Respiratory Infections ☐ Animals: _____ ☐ Change in temperature ☐ Dust
☐ Odors/Fumes ☐ Mold ☐ Other: _____

- b) Age of student when asthma was first diagnosed: _____

- c) Date of last asthma episode: _____ are the episodes: ☐ Same ☐ Better ☐ Worse

- d) How often does your child use their rescue inhaler: ☐ Rarely ☐ Occasionally ☐ Monthly ☐ Weekly ☐ Daily

- e) Ever been hospitalized due to asthma? ☐ Yes ☐ No If yes, explain: _____

3. Trigger and Symptoms:

- a. What are the early signs and symptoms of your student's asthma episode? (Be specific; include things the student might say) _____

- b. How does your child communicate his/her symptoms? _____

- b. How quickly do symptoms appear after trigger? Within: _____ seconds _____ mins _____ hrs _____ days

- c. Please check the symptoms your child has experienced in the past:

General	Abdominal	Throat	Lungs	Heart
☐ Trouble seeing caused by coughing, shortness of breath, wheezing	☐ Nausea	☐ Itching	☐ Shortness of breath	☐ Increased pulse
☐ Frequent respiratory infections	☐ Vomiting	☐ Tightness	☐ Repetitive Cough	☐ Loss of consciousness
☐ Delayed recovery of Bronchitis episodes		☐ Intermittent cough	☐ Whistling or wheezing when exhaling	☐ Chest pain
☐ Limited exercise because of shortness of breath		☐ Frequent cough	☐ Chest congestion	
☐ Fatigue/tired			☐ Chest tightness	

4. Treatment:

- a. How is asthma being treated? _____

- b. What medication is the student taking (both daily and rescue)? _____

- c. How effective is the student's response to treatment? _____

- d. Has there ever been an emergency room visit? ☐ No ☐ Yes, explain: _____

- e. Was the student admitted to the hospital? ☐ No ☐ Yes, explain: _____

- f. Has your healthcare provider provided you with a prescription for medication? ☐ No ☐ Yes

- g. Have you used the treatment or medication? ☐ No ☐ Yes

- h. Please describe any side effects or problems your child had in using the suggested treatment: _____

****Continued on reverse**

5. Self Care:

- a. Is your student able to recognize and monitor their asthma symptoms? ☐ No ☐ Yes
- b. Does your student:
- 1 Know what triggers to avoid..... ☐ No ☐ Yes
 - 2 Communicate asthma symptoms..... ☐ No ☐ Yes
 - 3 Tell an adult immediately when symptoms occur..... ☐ No ☐ Yes
 - 4 Wear a medical alert bracelet, necklace, watchband..... ☐ No ☐ Yes
 - 5 Tell peers and adults about their asthma..... ☐ No ☐ Yes
- c. Does your student know how to use their emergency medication? ☐ No ☐ Yes
- d. Has your child ever administered their own emergency medication? ☐ No ☐ Yes

6. Family/Home

- a. Does your child carry a rescue inhaler in the event of an asthma episode? ☐ No ☐ Yes
- b. Has your child ever had to use a rescue inhaler? ☐ No ☐ Yes
- c. Do you feel that your child needs assistance in coping with his/her asthma? ☐ No ☐ Yes

7. General Health:

- a. How is your child's general health other than having asthma? _____
- b. Does your child have other health conditions? _____
- c. Please add anything else you would like the school to know about your child's health:

8. Notes:

Parent/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____