

SMART THERAPY ASTHMA CARE PLAN

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____
 School: _____ 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 9-1-1 may be called if an 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:

SMART THERAPY MEDICATION:

Symbicort (____mcg budesonide/4.5mcg formoterol) **OR** **Dulera** (____mcg mometasone/5mcg formoterol)

Morning dose used at home: ____ puffs Evening dose used at home: ____ puffs

Use spacer with inhaler (MDI)

TRIGGERS: Weather Illness Exercise Smoke Dust Pollen Poor Air Quality Other:

Life threatening allergy specify: _____

SMART THERAPY 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	<ul style="list-style-type: none"> No current symptoms Strenuous activity planned 	<p>PRETREATMENT FOR STRENUOUS ACTIVITY, please choose ONE:</p> <p><input type="checkbox"/> Not required OR <input type="checkbox"/> Student/Parent request OR <input type="checkbox"/> Routinely</p> <ol style="list-style-type: none"> Give SMART THERAPY MED 15 minutes before activity: ____ puff(s) Have student rinse mouth with water and spit it out after puffs. <p><i>If child is currently experiencing symptoms, follow YELLOW or RED ZONE.</i></p>
YELLOW ZONE: Mild symptoms	<ul style="list-style-type: none"> Trouble breathing Wheezing Frequent cough Chest Tightness Not able to do activities 	<ol style="list-style-type: none"> Give SMART THERAPY MED: ____ puff(s) Stay with child/youth and maintain sitting position REPEAT SMART THERAPY MED if not improving in 15 minutes: ____ puff(s). If symptoms do not improve or worsen, follow RED ZONE. Once symptoms are relieved, have the student rinse their mouth with water and spit it out; they may then return to normal activities. Notify parents/guardians and school nurse
RED ZONE: EMERGENCY Severe	<ul style="list-style-type: none"> Coughs constantly Struggles to breathe Trouble talking (only speaks 3-5 words) Skin of chest and/or neck pull in with breathing Lips/fingernails gray/blue 	<ol style="list-style-type: none"> Give SMART THERAPY MED: ____ puff(s), if no improvement can repeat every 1-3 minutes, up to 5 puffs total (including any given in green or yellow zone). Call 9-1-1 and provide a report of the situation. Stay with child/youth. Remain calm, encourage slower, deeper breaths. Notify parents/guardians and school nurse

****Do not give more than 5 puffs total at school unless otherwise directed by parent or doctor.****

 Health Care Provider Signature Print Provider Name Date

 Fax Phone

 School Nurse CCHS Signature Date

Self-carry contract on file. Anaphylaxis plan on file for life threatening allergy to: