BENTONVILLE SCHOOLS - Asthma Care Plan

Student Name: _____ Date: _____

Birthdate:_____School:_____ Grade: _____

Parent/Guardian Name:_____ Phone: _____

Health Care Provider:_____ Phone: _____

Asthma History: _____

Triggers: ☐ Animal Dander ☐ Colds ☐ Mold ☐ Pollen ☐ Smoke ☐ Exercise ☐ Food ☐ Other_____

Student may self-carry Inhaler: ☐ Yes ☐ No

Rescue Medication	**Dose**	**# of puffs**	**Frequency**	**Pharmacy**	**RX#**

Nursing Care Plan

Symptoms: (Green Zone)	**Symptoms (Yellow)**	**Symptoms: (Red)**
Breathing is good	Shortness of breath	Very short of breath
No Cough/Wheeze	Cough &/or Wheeze	Cannot talk/play
No tightness of chest	Chest tightness	**Medication not helping after 15 mins.**
Can work/play	Labored breathing upon work/play	Cough/Wheeze/Chest getting worse
Other:	Other:	Lips/fingers blue-grey
		Other:
Actions:	**Actions:**	**Actions:**
*Assess student and document	*Assess student and document.	**CALL 911**
Medication:	**Give medication:**	***Give medication:**
Dose:	Medication:	Medication:
Frequency	Dose:	Dose:
*Avoid asthma triggers.	Frequency:	Frequency:
	*Assess student in 5-15 minutes. If Symptoms DO NOT improve to **GREEN zone**: **then-**	*Assess student in 5-15 minutes. If Symptoms DO NOT improve to **YELLOW zone**: **then-**
Give this Dose before PE or Exercise	*Avoid asthma triggers.	*Call parent and doctor NOW.
	*If little or no improvement, or no medication is available call parent or MD	***If no medication is available, call 911**

I give my permission for the asthma medication and/or inhaler/nebulizer medication to be given at school. If the nurse has a question about medication/orders/diagnosis, (s)he may contact the prescribing physician. In the absence of the school nurse, the medication may be given by appropriately trained and authorized BSD Personnel. The Nurse may share this medical information on an "as need to know" basis with BSD staff.

Signature of Parent/Guardian_____ **Date**_____

Health Care Provider Signature: _____ **Date:** _____

Reviewed by School Nurse_____ **Date**_____

Medication/Equipment Check In-Out

Date	Item	Parent Signature	Nurse Signature