ASTHMA CARE PLAN AND MEDICATION ORDERS

Plan ____ of ____

Place student picture here

STUDENT NAME			**Birthdate**	
Grade	**School**	☐ **Bus #**	☐ **Walk**	☐ **Drive**
☐ **History of anaphylaxis**	**PE/Sports:** Day/Time/Periods			
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 (if student is using the quick relief inhaler > 2 times per week or requires frequent observation by school staff ➔**Notify nurse and parent/guardian)**
- Full participation in physical education and sports

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

- If student is coughing, wheezing, having difficulty breathing and/or complaining of chest tightness

  Administer 2 puffs ☐ Albuterol (Pro-air®, Ventolin HFA®, Proventil®) ☐ Levalbuterol (Xopenex®)

  ☐ Use spacer/holding chamber with inhaler

  ☐ Albuterol/Levalbuterol unit dose via nebulizer

  ☐ Other_____

  ☐ May repeat in 10 minutes. ➔ **Notify nurse and parent/guardian if repeated**
- Until symptoms are in the GO ZONE (green), restrict strenuous physical activity
- **If no improvement after repeated dose Call 911—See below**

STOP ZONE (RED) CALL 911 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 _____

EXERCISE PRE-TREATMENT: (check all that apply) ☐ N/A

☐ 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		Parent/Guardian	
	Name		Name
	Primary #		Primary #
	Other #		Other #
	Other #		Other #

Name:	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	☐ Yes	☐ No	Provide extra for office	☐ Yes ☐ No
My child may carry their rescue inhaler and/or EAI-needs assistance to administer	☐ 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.
- Medical information may be shared with school staff working with my child and 911 staff, if they are called.
- 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.
- 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.

Does the student need classroom, school activity or recess accommodations ☐ Yes ☐ No **If yes, please contact the school counselor or 504 coordinator.**

I have reviewed and agree with this health care plan/504 and medication/treatment order.

_____

Parent/Guardian Signature **Date**

Student (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.

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**

A copy of the Health Care Plan will be kept in the substitute folder and given to all staff members who are involved with the student.