ASTHMA CARE PLAN AND MEDICATION ORDERS

STUDENT NAME:		Birthdate:
Grade:	School:	Bus ☐ #____Walk ☐ Drive ☐
Brief medical history:		

Asthma Triggers (check all that apply) ☐ Unknown ☐ Animals ☐Cold Air ☐ Exercise ☐ Pollens
☐ Respiratory illness/virus ☐ Smoke, chemicals, strong odors ☐ Other _____

Usual Asthma Symptoms (check all that apply) ☐ Cough ☐ Wheeze ☐ Shortness of breath
☐ Chest tightness ☐ Asking to use inhaler ☐ Other: _____

Inhaler location: ☐ Office ☐ Backpack ☐ On person ☐ Other: _____
Epinephrine auto-injector(s) (EIA) 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 >2times per week or requires frequent observation by school staff ➡ **Notify nurse and parent/guardian**

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: ☐ Alubuterol inhaler (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 acitity
- **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 of lips or nails, quick relief medication is not working:

- CALL 911
  - ☐ Give 4 puffs of quick relief inhaler (or nebulizer treatment)
  - ☐ Administer Epinephrine auto-injector (EIA) ☐ 0.3 mg ☐ 0.15 mg (Jr)
  - ☐ Other: _____

EXERCISE PRE-TREATMENT: (check all that apply) ☐ N/A
☐ Give 1-2 puffs of quck relief inhaler 15-30 minutes prior to PE or other strenuous exercise
If asthma symptoms continue to occur during exercise follow CAUTION ZONE (YELLOW) instructions. Notify nurse and parent/guardian if this occurs.

Daily controller medication: _____ Dose: _____ Time: _____
☐ Takes controller medication at home ☐ Administers daily controller medication at school
SIDE EFFECTS of medication(s): increased heart rate, shakiness

This student has demostrated 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 printed name:	
Start Date:	End date: ☐ Last day of school ☐ Other: _____	
Date:	Telephone #	Fax #

Asthma Care Plan TO BE COMPLETED BY: Parent/Guardian

Student name: _____

EMERGENCY CONTACTS:

Parent/Guardian	Name	Parent/Guardian	Name
	Primary #		**Primary #**
	Other#		**Other#**

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 EpiPen® ☐ yes ☐ no Provide extra for office ☐ yes ☐ no
My child may carry their rescue inhaler and/or EpiPen®--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 the 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 Health Care Providers (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 plan coordinator.

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

_____

Parent/Guardian's Signature **Date**

Student (for student who self-carries/administers rescue inhaler and/or EpiPen®)

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

_____

Student Signature (required) **Date**

The care plan is intended to strengthen the partnership of families, health care 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 the asthma care plan in conjunction with the student, their parent/guardian and their LHP. Student may carry and self-administer the medication 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

Devices if any, used _____ Expiration date: _____

_____

Registered Nurse Signature **Date**