

# ASTHMA CARE PLAN AND MEDICATION ORDERS

Plan \_\_\_\_\_

Place student picture here

<b>STUDENT NAME</b>				Birthdate	
Grade	School	<input type="checkbox"/> Bus #	<input type="checkbox"/> Walk	<input type="checkbox"/> Drive	Weight: _____
<input type="checkbox"/> 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 → <b>Notify school nurse-phone # _____ and parent/guardian.</b>	GREEN ZONE Peak Flow Range _____ to _____ <input type="checkbox"/> N/A Peak Flow
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**YELLOW**

<b>SYMPTOMS INCREASE:</b> Cough, wheeze, chest tightness, or shortness of breath, can do some, but not all, usual activities <b>ADMINISTER</b> <input checked="" type="checkbox"/> Quick-relief Medication: _____ <b>Number of puffs:</b> _____ <input type="checkbox"/> Use spacer/chamber with inhaler <b>OR</b> <input type="checkbox"/> Quick-relief Medication via Nebulizer: _____ <b>Dosage:</b> _____ <b>Can repeat every _____ minutes up to maximum of _____ doses</b> <ul style="list-style-type: none"> <li>○ If symptoms (and peak flow, if used) resolve student returns to GREEN ZONE guidance</li> <li>○ If symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:  <b>Administer</b> <input type="checkbox"/> Quick-relief Medication: _____ <b>Number of puffs:</b> _____  <input checked="" type="checkbox"/> Nebulizer (2<sup>nd</sup> dose)</li> </ul> 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 _____
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**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 ➤ <b>CALL 911</b> <input checked="" type="checkbox"/> Give 4 puffs quick relief inhaler (or nebulizer treatment) <input type="checkbox"/> Administer epinephrine auto-injector (EAI) <input type="checkbox"/> 0.3 mg <input type="checkbox"/> 0.15 mg (Jr) <input type="checkbox"/> Other _____ Contact school nurse (if available) and parent/guardian. Adult stays with student	RED ZONE Peak Flow Range Below: _____
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**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

<b>Parent/Guardian</b>	Name	<b>Parent/Guardian</b>	Name
	Primary #		Primary #
	Other #		Other #
	Other #		Other #
Name:		Relationship:	Phone:

My child may carry and is trained to administer their rescue inhaler	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Provide extra for office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child may carry and is trained to self-administer their EAI	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Provide extra for office	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child needs to carry their rescue inhaler and/or EAI- and will need assistance with administration	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

<b>For School District Nurse Only</b>		<b>504 Plan</b> <input type="checkbox"/>
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: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Device(s) if any, used	Expiration date(s)	
<b>Registered Nurse Signature:</b>	<b>Date:</b>	<b>Phone number:</b>