

Garretson School District 49-4
505 2nd St. PO Box C
Garretson, SD 57030
Phone (605) 594-3451
Fax (605) 594-3443

Year 20__/_/___

Asthma Care Plan

Students Name _____ Date of Birth ____/____/____
Bus: ☐ Yes ☐ No Teacher _____ Grade _____
Parent/Guardian _____ Phone _____
_____ Phone _____
Emergency Contact 1) _____ Phone _____
2) _____ Phone _____
Physician: _____ Phone _____
Pulmonologist: _____ Phone _____

Asthma History to be Completed by Parent

1. When was your child's asthma first diagnosed? _____
2. How would you rate the severity of your child's asthma? 1 = not severe 10 = severe
Please Circle: 1 2 3 4 5 6 7 8 9 10
3. In the past month, how often has your child had coughing, wheezing, or breathing difficulties?
☐ 2 times a week or less ☐ More than 2 times a week ☐ Daily
4. How many times has your child been treated in the ER or hospitalized for asthma in the past year? _____
5. What triggers your child's asthma? (please check all that apply)
☐ Colds ☐ Air Pollution ☐ Smoke ☐ Animals ☐ Exercise ☐ Carpets
☐ Dust ☐ Mold ☐ Pollen ☐ Change in Weather
☐ Food _____ ☐ Other _____
6. What does your child do at home to relieve asthma symptoms? (please check all that apply)
☐ Rest/Relaxation ☐ Drink Liquids ☐ Medication (please list below) ☐ Other _____
7. List medications your child takes for asthma on a daily basis or as needed:

Medication	Dose	How Often

8. Is your child able to self-administer their asthma medication? ☐ Yes ☐ No

By signing below, I understand that I am giving my permission to share this information with school staff/trained personnel as needed with strict confidentiality. I also give my permission for the school nurse/aide to contact the Primary Care Physician or Pulmonologist if further information or clarification is needed.

Parent/Guardian Signature _____ Date _____

TO BE COMPLETED BY PHYSICIAN:

Severity Classification	Triggers	Exercise												
<input type="checkbox"/> Mild Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent	<input type="checkbox"/> Colds <input type="checkbox"/> Air pollution <input type="checkbox"/> Smoke <input type="checkbox"/> Exercise <input type="checkbox"/> Carpets <input type="checkbox"/> Dust/Chalk Dust <input type="checkbox"/> Mold <input type="checkbox"/> Pollen <input type="checkbox"/> Other _____ <input type="checkbox"/> Animals <input type="checkbox"/> Change in temperature <input type="checkbox"/> Food _____	1. Pre-medication Exercise <table border="1"> <thead> <tr> <th>Medication</th> <th>Dose</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> </tbody> </table> 2. Exercise modifications _____	Medication	Dose										
Medication	Dose													
GREEN ZONE: Doing Well														
Symptoms <ul style="list-style-type: none"> Breathing is good No cough or wheeze Can work and play Sleeps all night 	Peak Flow Meter Personal Best = Control Medications: <table border="1"> <thead> <tr> <th>Medication</th> <th>Dose</th> <th>Time</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>		Medication	Dose	Time									
Medication	Dose	Time												
YELLOW ZONE: Getting Worse														
Symptoms <ul style="list-style-type: none"> Some problems breathing Cough, wheeze or chest tight Problems working or playing Awake at night 	Contact Physician if using quick relief more than 2 times per week. 1) Continue control medicines and ADD quick relief medication: Medicine: _____ Dose: _____ 2) IF your symptoms DO NOT return to the Green Zone after 1 hour of the quick relief treatment, THEN: <input type="checkbox"/> Take quick-relief treatment again <input type="checkbox"/> Change your long-term control medicines by _____ <input type="checkbox"/> Call your physician within _____ hours of modifying your medication routine													
RED ZONE : Medical Alert														
Symptoms <ul style="list-style-type: none"> Lots of problems breathing Cannot work or play Getting worse instead of better Medicine is not helping 	Ambulance/Emergency Phone Number: 1) Continue control medicines and ADD quick-relief medication: Medicine: _____ Dose: _____ 2) Call physician NOW 3) Go to the hospital or call 911 for an ambulance if <input type="checkbox"/> Still in the red zone after 15 minutes <input type="checkbox"/> If you have not been able to reach your physician for help 4) Call an ambulance immediately if the following danger signs are present <input type="checkbox"/> Trouble walking/talking due to shortness of breath/blue lips or fingernails													

Child may carry and self-administer Asthma medications: ☐ Yes ☐ No

***A Medication and Treatment Authorization Form** must be completed and kept on file in the school health office. New health care plans must be completed yearly. Any updates throughout the school year should be submitted to the Nurse.

***In Garretson**, in the event of an emergency, EMS will be activated by a call to 911 at which time we will state the need to transport to hospital by ambulance. Trained school staff respond first, followed by Garretson volunteer ambulance and fire departments.

**This information will become part of your child's confidential permanent record. If for any reason you do not wish to respond to part(s) of this form you are under no obligation to do so. Please understand that we are not responsible for injury or illness that may result from these omissions.*

Physician Signature _____ Date _____

School Nurse Signature _____ Date _____