**ASTHMA CARE PLAN AND MEDICATION ORDERS Plan \_\_\_\_ of \_\_\_\_**

Place  
student   
picture   
here

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STUDENT NAME** | | | | |  | | | | | | | | | **Birthdate** | |  | |
| **Grade** |  | | **School** | | | | | **Bus #**  **Walk**  **Drive** | | | | **Weight: Height:** | | | | | |
| **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 🡺 **Notify school nurse-phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and parent/guardian.** | | | | | | | | | | | | | | | | | GREEN ZONE Peak Flow Range  to  N/A Peak Flow |
| **CAUTION ZONE (YELLOW) *SIGNIFICANT SYMPTOMS DO NOT LEAVE STUDENT UNATTENDED*** | | | | | | | | | | | | | | | | | |
| **SYMPTOMS INCREASE:** Cough, wheeze, chest tightness, or shortness of breath, can do some, but not all, usual activities  **ADMINISTER  Quick-relief Medication:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Number of puffs:** \_\_\_\_\_\_\_\_\_ **Use spacer/chamber with inhaler**  **OR  Quick-relief Medication via Nebulizer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dosage:** \_\_\_\_\_\_\_\_\_  **Can repeat every \_\_\_\_\_ minutes up to maximum of \_\_\_\_\_ doses**   * + If symptoms (and peak flow, if used) resolve student returns to GREEN ZONE guidance   + If symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:   **Administer  Quick-relief Medication:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Number of puffs:** \_\_\_\_\_\_  **OR  Nebulizer** (2nd dose)  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 |
| **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   * **CALL 911**  Give 4 puffs quick relief inhaler (or nebulizer treatment)   Administer epinephrine auto-injector (EAI) 0.3 mg 0.15 mg (Jr) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact school nurse (if available) and parent/guardian. Adult stays with student | | | | | | | | | | | | | | | | | RED ZONE Peak Flow Range  Below: |
| **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 | | | |  | | |

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**Asthma Care Plan – Part 2 – Parent/Guardian**

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| **STUDENT NAME** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
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**EMERGENCY CONTACTS**

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

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| --- | --- | --- | --- | --- |
| Name: | Relationship: |  | Phone: |  |

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| --- |
| 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 needs to carry their rescue inhaler and/or EAI- and will need assistance with administration  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.
* 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.

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| **Parent/Guardian Signature** | **Date** |

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| **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. | |

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| **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:** | | | | **Phone number:** |

A copy of the Health Care Plan will be available to all staff members who are involved with the student, including substitutes. Rev 4/14/2021

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