Ware County School Health Services
Asthma Plan of Care for School Year 2023 - 2024

Student Information

Student Name: ____ DOB: ___/___/___ Sex: _________ Race: _________

School: ________________________________ Homeroom Teacher: __________________________ Grade: _________

Medications

Controller Medicines	How much to take	How often	Other instructions
		___ times per day EVERY DAY	☐ Gargle or rinse mouth after use
		___ times per day EVERY DAY	
		___ times per day EVERY DAY	
Quick-relief Medicines	**How much to take**	**How often**	**Other instructions**
	☐ 2 puffs ☐ 4-6 puffs ☐ 1 neb treatment	Take ONLY as needed (see below – starting in YELLOW ZONE or before exercise)	NOTE: If you need this medicine more than 2 days a week, call your doctor.

If an **Inhaler** or **Epinephrine Kit** has been ordered, this student has been trained in its use, is responsible, and may carry on person at all times ________yes ________no (initial one). These orders remain in effect until discontinued in writing by parent and/or physician.

ASTHMA TRIGGERS (check all that apply)

❏ Exercise ❏ Change in temperature ❏ Molds ❏ Animals ❏ Strong odors or fumes ❏ Smoke
❏ Pollens ❏ Respiratory infections ❏ Dust ❏ Strong emotions ❏ Food/Other___________________________

Special instructions to follow when I am Doing Well, I Need to be Careful, or I Need HELP.

Zone		
GREEN ZONE	**I am Doing Well.** • No coughing, wheezing, chest tightness, shortness of breath during the day or night • Can go to school and play	**PREVENT** asthma symptoms every day by: ☐ Take my controller medicines (above) every day ☐ Before exercise, take ______ puff(s) of ___________________ ☐ Avoid triggers that make my asthma worse (see above)
YELLOW ZONE	**I Need to Be Careful.** • Coughing, wheezing, chest tightness, shortness of breath • Waking at night due to asthma symptoms • Can do some, but not all, usual activities • Runny nose, watery eyes	**CAUTION:** Continue taking my controller medication every day. ☐ Take ______ puffs or ______ nebulizer treatment(s) of quick relief medicine. If I am not back in the **GREEN ZONE** within one hours, then I should: ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in ______ days. ☐ Increase _________________________________ ☐ Add ____________________________________
RED ZONE	**I Need HELP.** • Very short of breath • Continual coughing • Skin between ribs is pulling inwards • Difficulty speaking without running out of breath • Quick-relief medicines have not helped • Symptoms same or worse after 48 hours in the **YELLOW ZONE**	**MEDICAL EMERGENCY!** Get Help Now! ☐ Take quick-relief medicine ______ puffs every ______ minutes and get help immediately ☐ Take ___________________________________ ☐ Call ____________________________________ ☐ IF skin, fingernail, or lip color is blue at any time **Call 911** for help or go to the nearest **EMERGENCY DEPARTMENT**

Physician Name: ____ Office Number: ____________________

Physician Signature (No Stamp Please) X____ Date ____________

Parent/Guardian Name: ____ Phone Number: ____________________

Parent/Guardian Signature X____ Date: ____________

Parent/Guardian signature indicates acknowledgement and release for sharing medical information between our student's physician and other health care providers and authorizing the designates school nurse to share medical information with other school employees as necessary.