Date Received ____________
Date Revised ____________

# ASTHMA CARE PLAN for

| Student Name: | | | Routine medications (at home and school) |
|---|---|---|---|
| Date of Birth: | School: | Grade: | |
| Transportation: Bus # ____________ Car Walk | | | Preferred Hospital: |
| Does student have severe allergies? No Yes (See Severe Allergic Reaction Care Plan) | | | |
| Location where Inhaler(s) / Rescue medication(s) is/are stored: Health Office Backpack On Person Locker # __________ Other __________ | | | |

Triggers: Weather (cold air / wind) Illness Exercise Smoke Dog Dust Mold Pollen Cat
Other: ______________________________________________

## GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health Care Provider check all that apply)

Give 2 puffs of rescue medication *(name)*: ______________________
Give 15 minutes before activity as needed (circle indication: Phy Ed class, exercise/ sports, recess) Explanation: ______________________________
Repeat in 4 hours if needed for additional or ongoing physical activity.

## YELLOW ZONE: SICK—UNCONTROLLED ASTHMA (Health Care Provider complete dosing for rescue inhaler/nebulizer)

| IF YOU SEE THIS: | DO THIS: |
|---|---|
| • Difficulty breathing<br>• Wheezing<br>• Frequent cough<br>• Complains of chest tightness<br>• Unable to tolerate regular activities but still talking<br>• in complete sentences<br>• Other: ____________________________ | • Stop physical activity<br>• Give rescue medication *(name)*: ____________________________<br>• 1 puff 2 puffs other: ____________ Via spacer<br>• If no improvement in 10-15 minutes, repeat use of rescue medication:<br>• 1 puff 2 puffs other: ___________ Via spacer<br>• Student may sip water slowly<br>• Stay with student and help them to maintain a sitting position<br>• Call parent/guardian<br>• Student may resume normal activities once feeling better<br>• If student’s symptoms do not improve or worsen, call 911 and district nurse |

- **If there is no rescue inhaler at school:**
  - ⇒ **Call parent/guardian to pick up student and/or bring inhaler / medication to school.**
  - ⇒ **Inform them that if they cannot get to school, 911 may be called.**

## RED ZONE: EMERGENCY SITUATION (Health Care Provider complete dosing for rescue inhaler/nebulizer)

| IF YOU SEE THIS: | DO THIS IMMEDIATELY: |
|---|---|
| • Coughs constantly<br>• Nostrils flaring, struggles or gasps for breath<br>• Stooped over posture<br>• Trouble talking (only able to speak 3-5 words)<br>• Skin of chest and/or neck pull in with breathing<br>• Lips or fingernails are gray or blue<br>• Anxiety or fear<br>• Confused or decreased level of consciousness<br>• Other: ___________________________ | • Give rescue medication *(name)*: ____________________________<br>1 puff 2 puffs other: ____________ Via spacer<br>• If no improvement in 10-15 minutes, repeat use of rescue medication:<br>1 puff 2 puffs other: ____________ Via spacer<br>• Call 911 - Inform emergency personal that the reason for the call is asthma<br>• Call parent/guardian and district nurse<br>• Help student maintain a sitting position<br>• Encourage student to take slower deeper breaths<br>• Stay with student and remain calm |

## ORDERS AND INSTRUCTIONS for RESCUE INHALER / NEBULIZER USE: (HEALTH CARE PROVIDER: PLEASE CHECK ALL THAT APPLY)

Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently.
Student is to notify his/her designated school health staff after using inhaler.
Student needs supervision or assistance to use his/her inhaler.
Student has life threatening allergy (See Severe Allergic Reaction Care Plan)

Grades 7—12 may self carry inhaler

| Medication Name: | | Possible side effects: |
|---|---|---|
| Medication Strength: | Dose: | Frequency: |
| Additional instructions: | | |
| **Health Care Provider Signature:** | | Date: |
| Phone Number: | | Fax: |

Asthma Care Plan for

Student Name ___________________________________

**Individual Considerations**

**Field Trip Procedures**

Rescue medication to accompany student during any off campus activities.
Staff members on trip must be trained regarding medication use and student health care plan (plan must be taken).
Other (specify):

**Bus—Transportation should be alerted to student's asthma.**

This student carries Inhaler on the bus: Yes No

Inhaler can be found in: Backpack On person

Student will sit at front of the bus: Yes No

**Other consideration:**

## EMERGENCY CONTACTS

| 1. | Relationship: | Day Phone: | Cell Phone: |
|---|---|---|---|
| 2. | Relationship; | Day Phone: | Cell Phone: |
| 3. | Relationship: | Day Phone: | Cell Phone: |
| 4. | Relationship: | Day Phone: | Cell Phone: |

- I approve this *Asthma Care Plan* for my child.
- I request this medication to be given as ordered by the Health Care Provider.
- I give consent to share information about my child's asthma with the district nurse, health assistant, teachers, principal, office staff, guidance, bus driver/transportation, cafeteria workers, playground staff, and emergency staff on a "need to know basis".
- I give Health Services Staff permission to communicate with the medical office about this care plan / medication. I understand the medication(s) will not necessarily be given by the district nurse, but may be given by the health assistant or designated trained staff.
- Parent/guardian must provide medication/equipment required to administer medication or provide special medical care.
- All medication supplied must come in its **original** *pharmacy-labeled* container; and the container specifies the student's name, name of prescriber, the name of medication, the dose, the effective date, and the directions for administration.
- (Grades 7-12) I request and authorize my child to carry and/or self-administer their medication . Yes No
  This permission to posses and self-administer an Inhaler may be revoked by the principal/district nurse if it is determined that your child is not safely and effectively able to self-administer.
- Any changes in medication require a new written authorization and corresponding change in the prescription label.
- I understand that the medication maintained in the health room is not available after school hours, and that I need to provide additional rescue medications for my child when involved in sports/activities after school hours.

Parent/Guardian Signature ______________________________________________ Date ______________________

District Nurse Signature ____________________________________________________ Date Reviewed ________________

Fax Numbers:

| | | | |
|---|---|---|---|
| Big Bend 262-662-1309 | Clarendon 262-363-6289 | Eagleville 262-594-5495 | Prairie View 262-392-6312 |
| Rolling Hills 262-363-6343 | Section 262-363-6341 | Park View 262-363-6320 | Mukwonago High 262-363-6239 |

District Nurse Phone: 262-363-6292 x27515 Fax: 262-363-6320