COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS

	RADO ASTRIVIA CARE PLAN A				
PARENT/GUARDIAN COMPLETE AND SIGN:			School/grade:		
		Bi			
Parent	/Guardian Name:	Pr	Phone:		
Healthcare Provider Name: Phone:					
Triggers: □ Weather (cold air, wind) □ Illness □ Exercise □ Smoke □ Dust □ Pollen □ Other:					
☐ Life threatening allergy, specify:					
I give permission for school personnel to share this information, follow this plan, administer medication and care for my child/youth, and if necessary, contact our healthcare provider. I assume full responsibility for providing the school/program prescribed medication and supplies, and to comply with board policies, if applicable. I am aware 911 may be called if a quick relief inhaler is not at school and my child/youth is experiencing symptoms. I approve this care plan for my child/youth. PARENT SIGNATURE DATE NURSE/CCHC SIGNATURE DATE					
HEALTHCARE PROVIDER		QUICK RELIEF (RESCUE) MEDICATION: Albuterol Other: Common side officials Absorbusta to make the common of the common side of the common of			
COMPLETE ALL ITEMS,		Common side effects: ↑ heart rate, tremor ☐ Have child use spacer with inhaler.			
SIGN AND DATE:		Controller medication used at home:			
IF YOU SEE THIS:		DO THIS:			
IE: ns	 No current symptoms 	Pretreat strenuous activity: ☐ Not required ☐ Routine ☐ Student/Parent request			
ON otor	 Doing usual activities 	Give QUICK RELIEF MED 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs			
EEN ZOR Symptor Pretreat		☐ Repeat in 4 hours, if nee	f needed for additional physical activity.		
GREEN ZONE: No Symptoms Pretreat		f child is currently experiencing symptoms, follow YELLOW ZONE.			
<u>ö ž</u>					
	 Trouble breathing 	1. Stop physical activity.			
IE: πs	Wheezing	2. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs			
ON	 Frequent cough 	3. Stay with child/youth and maintain sitting position.			
V Z mp	 Complains of tight chest 	4. REPEAT QUICK RELIEF MED, if not improving in 15 minutes: \square 2 puffs \square 4 puffs			
OV Sy	 Not able to do activities, 	5. Child/youth may go back to normal activities, once symptoms are relieved.			
YELLOW ZONE: Mild symptoms	but talking in complete	, , , , , , , , , , , , , , , , , , , ,	nts/guardians and school nurse.		
⋝ Z	sentences	If symptoms do not improve or worsen, follow RED ZONE.			
	• Peak flow:&				
.Υ	 Coughs constantly 	1. Give QUICK RELIEF MED:			
ENC Sr	 Struggles to breathe 	 Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 			
KGI:	 Trouble talking (only speaks 	2. Call 911 and inform EMS the reason for the call.			
3. Stay with child/youth. Remain calm, encouraging slo				ng slower, deeper brea	iths.
Struggles to breathe Trouble talking (only speaks 3-5 words) Skin of chest and/or neck pull in with breathing Lips/fingernails gray or blue Level of consciousness Peak flow <					c.
					☐ 4 putts
20I 3Ve	Lips/fingernails gray or blue				
• \Psi Level of consciousness School personnel should not drive student to hospital.					
RE	• Peak flow <				
PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)					
☐ Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler.					
☐ Student understands proper use of asthma medications, and in my opinion, can carry and use his/her inhaler at school					
independently with approval from school nurse and completion of contract.					
☐ Student will notify school staff after using quick relief inhaler, if symptoms do not improve with use.					
HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER NAME DATE FAX PHONE					HONE
Copies of plan provided to: Teacher(s) PhysEd/Coach Principal Main Office Bus Driver Other					

