



COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS 2018/2019

PARENT/GUARDIAN COMPLETE AND SIGN: School/grade: Child Name: Birthdate: Parent/Guardian Name: 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.

Table with 4 columns: PARENT SIGNATURE, DATE, NURSE/CCHC SIGNATURE, DATE. Rows include: HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE; IF YOU SEE THIS: DO THIS; GREEN ZONE: No Symptoms Pretreat; YELLOW ZONE: Mild symptoms; RED ZONE: EMERGENCY Severe Symptoms.


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

Copies of plan provided to: Teacher(s) PhysEd/Coach Principal Main Office Bus Driver Other



Name:		Birth date:		
School:	Grade:	Primary Phone:		

### Asthma Self Carry Inhaler Contract

#### STUDENT AGREEMENT

- I plan to keep my rescue inhaler with me at school rather than in the school health office.
- I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.
- I will notify the school health office if I am having more difficulty than usual with my asthma.
- I will not allow any other person to use my inhaler.

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**STUDENT SIGNATURE**

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**PRINT STUDENT'S NAME**

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**DATE**

#### PARENT AGREEMENT

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

- I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.
- It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.
- I will review the status of the student's asthma with the student on a regular basis as agreed in the treatment plan.

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**PARENT SIGNATURE**

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**PRINT PARENT'S NAME**

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**DATE**

#### SCHOOL NURSE AGREEMENT

- The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.
- School staff that have the need to know about the student's condition and the need to carry medication have been notified.

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**SCHOOL NURSE SIGNATURE**

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**PRINT NURSE' NAME**

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**DATE**