

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

PARENT/GUARDIAN COMPLETE AND SIGN:			School/grade:			
Child Name:						
Parent/Guardian Name:			Phone:			
Health	care Provider Name:	Pl	Phone:			
Triggers: □ Weather (cold air, wind) □ Illness □ Exercise □ Smoke □ Dust □ Pollen □ Other:						
☐ Life threatening allergy, specify:						
youth, prescr	permission for school personnel to and if necessary, contact our hea ibed medication and supplies, and nhaler is not at school and my chi	Ithcare provider. I assume full I to comply with board policies	responsibility, if applicable.	for providing the sch I am aware 911 may	nool/program y be called if a quick	
PARENT SIGNATURE		DATE NURSE/CCHC SIGNATURE DATE				
HEALTHCARE PROVIDER		QUICK RELIEF (RESCUE) MEDICATION: Albuterol Other:				
COMPLETE ALL ITEMS,		Common side effects: \uparrow heart rate, tremor \Box Have child use spacer with inhaler.				
SIGN AND DATE:		Controller medication used at home:				
IF YOU SEE THIS:		DO THIS:				
IE:	No current symptoms	Pretreat strenuous activity:	☐ Not requir	ed 🗆 Routine 🗆 Stu	udent/Parent request	
ON ton	 Doing usual activities 	Give QUICK RELIEF MED 10-	15 minutes b	efore activity: \square 2	puffs 4 puffs	
• No current symptoms • Doing usual activities • No current symptoms • Doing usual activities Pretreat strenuous activity: L Give QUICK RELIEF MED 10-1: Repeat in 4 hours, if needs If child is currently experience.				needed for additional physical activity.		
Sy Pr		If child is currently experiencing symptoms, follow YELLOW ZONE.				
ijž						
	 Trouble breathing 	1. Stop physical activity.				
YELLOW ZONE: Mild symptoms	Wheezing	2. Give QUICK RELIEF MED:	☐ 2 puffs ☐	4 puffs		
	Frequent cough	3. Stay with child/youth and	maintain sitt	ting position.		
/ Z/	Complains of tight chest	4. REPEAT QUICK RELIEF ME	D, if not imp	roving in 15 minutes	s: 2 puffs 2 4 puffs	
OW	 Not able to do activities, 	5. Child/youth may go back	to normal act	tivities, once sympto	oms are relieved.	
ild i	but talking in complete	6. Notify parents/guardians and school nurse.				
¥ ≥	sentences	If symptoms do not improve or worsen, follow RED ZONE.				
	• Peak flow:&					
≿	 Coughs constantly 	1. Give QUICK RELIEF MED:	☐ 2 puffs ☐	4 puffs		
• Struggles to breathe • Refer to anaphylaxis plan, if child/youth has life-threatening					ing allergy.	
GE	 Trouble talking (only speaks 	alking (only speaks 2. Call 911 and inform EMS the reason for the call.				
lER ipt	3-5 words)					
EN Ym	Skin of chest and/or neck 4. Notify parents/guardians and school nurse.					
 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 <					☐ 2 puffs ☐ 4 puffs	
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	
Copies	s of plan provided to: ☐Teacher(s)	☐ PhysEd/Coach ☐ Principal	☐Main Off	ice □Bus Driver Ot	ther	



Revised: March 2018