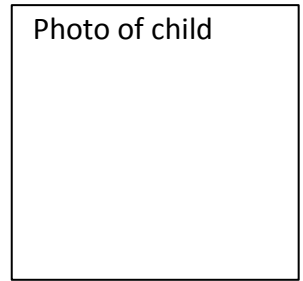




Photo of child

PARENT/GUARDIAN complete and sign the top portion of form.

Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
School and Grade:	Teacher:



Triggers: Weather (cold air, wind) Illness Exercise Smoke Dust Pollen Other: _____
 Life threatening allergy : Specify _____

If there is no quick relief inhaler at school and the student is experiencing asthma symptoms:

- Call parents/guardians to pick up student and/or bring inhaler/ medications to school
- Inform them that if they cannot get to school, 911 may be called

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ 504 PLAN OR IEP
 PARENT SIGNATURE DATE SCHOOL NURSE SIGNATURE DATE

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: Not Required
 Pretreatment for strenuous activity: Routinely **OR** Upon request Explain: (weather, viral, seasonal, other) _____
 Give 2 puffs of quick relief med (Check One): Albuterol Other: _____ 10-15 minutes before activity.
 Repeat in 4 hours if needed for additional or ongoing physical activity.
If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	DO THIS:
<ul style="list-style-type: none"> ▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between ____ and ____ ▪ Other: _____ 	<ol style="list-style-type: none"> 1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. <p><i>If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.</i></p>

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
<ul style="list-style-type: none"> ▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < _____ 	<ol style="list-style-type: none"> 1. GIVE QUICK RELIEF MED: (Check One): <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has no arrived and symptoms remain, repeat quick Relief medicine (up to 4 more puffs.) 8. <i>School personnel should not drive student to hospital.</i>

INSTRUCTIONS for QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently with approval from school nurse.

Student is to notify his/her designated school health officials after using inhaler.

Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) _____.

HEALTH CARE PROVIDER SIGNATURE PRINT PROVIDER'S NAME PHONE/FAX DATE

Copies of plan provided to: Teacher(s) ___ Phys Ed/Coach ___ Principal ___ Main Office ___ Bus Driver ___ Other _____