



COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS 2019/2020

PARENT/GUARDIAN COMPLETE AND SIGN: School/grade: Child Name: Birthdate: Parent/Guardian Name: Phone: Healthcare Provider Name: Phone: Triggers: 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

