Health Care Action Plan - Asthma

Please return form to: Resurrection Christian School Fax: 970 647 7385

Student Name _____ DOB _____ Grade _____

Emergency Contact Information

List contacts in order of preference. Also, write preference of contact method, 1 being the highest, 3 the lowest:

Contact #1 Name: _____ Contact #2 Name: _____

Home Phone: _____ Preference:____ Home Phone: _____ Preference:____

Cell Phone: _____ Preference:____ Cell Phone: _____ Preference:____

Work Phone: _____ Preference:____ Work Phone: _____ Preference:____

Health Care Provider who should be contacted regarding the asthma attacks:

Specialist _____ Phone _____

Symptoms and History of Asthma Attacks

Medication Provided to School for Treatment of Asthma

School Accommodations and Treatments (to be filled out by School Nurse)

I give permission for the information contained on this HCAP to be shared with adults in the school settings that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one school year or until the health status of physician's orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever there is any change in the student's health status or care.

Health Care Provider (MD/DO/NP/PA) Date Parent/Guardian Date School Nurse Date

COLORADO SCHOOL ASTHMA CARE PLAN

Photo of child

Name:	Birth date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
Home Phone:	Work Phone:
Other Contact:	Phone:
Preferred Hospital:	

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dog/Cat ☐ Dust ☐ Mold ☐ Pollen
Other:_____

GREEN ZONE: **PRETREATMENT STEPS FOR EXERCISE** (Health provider initial all that apply)

- ☐ Give 2 puffs of rescue med_____ 15 minutes before activity (Circle indication: Phys Ed class, exercise/sports, recess) Explanation:_____
- ☐ Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: **SICK – UNCONTROLLED ASTHMA** (Health provider complete dosing for rescue inhaler)

IF YOU SEE THIS:	**DO THIS:**
▪ Difficulty breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Unable to tolerate regular activities but still talking in complete sentences ▪ Other:	▪ Stop physical activity ▪ Give rescue med *(name)*:_____ ☐ 1 puff ☐ 2 puffs ☐ other:_____ ☐ Via spacer ▪ If no improvement in 10-15 minutes, repeat use of rescue med: ☐ 1 puff ☐ 2 puffs ☐ other:_____ ☐ Via spacer ▪ If student's symptoms do not improve or worsen, call 911 ▪ Stay with student and maintain sitting position ▪ Call parents/guardians and school nurse ▪ Student may resume normal activities once feeling better

- If there is **no rescue inhaler at school**:
  - ➢ 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

RED ZONE: **EMERGENCY SITUATION** (Health provider complete dosing for rescue inhaler)

IF YOU SEE THIS:	**DO THIS IMMEDIATELY:**
▪ Coughs constantly ▪ Struggles or gasps for breath ▪ Trouble talking (only able to speak 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness	▪ Give rescue med *(name)* :_____ ☐ 1 puff ☐ 2 puffs ☐ Other:_____ ☐ Via spacer ▪ Repeat rescue med if student not improving in 10-15 minutes ☐ 1 puff ☐ 2 puffs ☐ Other:_____ ☐ Via spacer ▪ Call 911 Inform attendant the reason for the call is asthma ▪ Call parents/guardians and school nurse ▪ Encourage student to take slower deeper breaths ▪ Stay with student and remain calm ▪ *School personnel should not drive student to hospital*

INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE 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
☐ Student is to notify his/her designated school health officials after using inhaler
☐ Student needs supervision or assistance to use his/her inhaler. If not self carry, the inhaler is located:_____
☐ Student has life threatening allergy, the epipen is located:_____

_____ _____ _____
HEALTH CARE PROVIDER SIGNATURE PLEASE PRINT PROVIDER'S NAME DATE

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.

_____ _____
PARENT SIGNATURE DATE

_____ _____ ☐ 504 Plan or IEP
School Nurse Signature DATE

Copies of plan provided to: Teachers __ Phys Ed/Coach __ Principal___ Main Office __ Bus Driver __ Other _____