COLORADO SCHOOL ASTHMA CARE PLAN:

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:_____

☐Give 2 puffs of _____rescue med ☐ 15 minutes before activity. Indications: ☐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

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 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, <u>can carry and use his/her inhaler at school independently</u>

☐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 PROVIDERS NAME | START DATE | END 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 | SCHOOL NURSE SIGNATURE | DATE

Copy of plan provided to: ☐ Teachers ☐ Phys Ed/Coach ☐ Principal ☐ Main Office ☐Bus Driver ☐ Other ☐ 504 Plan or IEP

Exhibit Code: 5141

PHYSICIAN ORDER / HEALTH PLAN FOR STUDENT TO CARRY EMERGENCY MEDICATION AT SCHOOL

STUDENT NAME _____ MEDICATION NAME _____

As specified in Superintendent's Policy 5141, there are a few specific and significant situations when a health care provider will write directions for a student to keep emergency medication with them at all times, even during the school day.

Considerations for self carry should include the student's age and capability to self-administer emergency medication as well as the student's ability to comply with the District's policy on carrying emergency medication.

SAFETY AND PROTECTION IS PARAMOUNT FOR ALL STUDENTS AT SCHOOL AT ALL TIMES – THEREFORE THERE ARE CERTAIN RESPONSIBILITIES THAT THE FAMILY AND STUDENT MUST ASSUME WHEN THE STUDENT WILL CARRY EMERGENCY MEDICATION DURING THE SCHOOL DAY.

By signing, below, I/we agree to comply with the terms of this plan and the provisions of Superintendent Policy 5141. Parent/guardian releases Adams 12 Five Star Schools, its employees, agents, and volunteers from any and all liability related to the student's self administration of ordered medication(s) except that parent/guardian does not waive any claim related to the willful or wanton misconduct by the District or its employees, agents, and volunteers.

CONTRACT FOR STUDENT TO CARRY AND SELF-ADMINISTER EMERGENCY MEDICATION

- Healthcare provider confirms that the student has been instructed in and is capable of self-carry ***and*** self-administration of the ordered emergency medication.
- Physician has completed the medication order on the reverse side.

PHYSICIAN Signature: _____ **DATE**: _____

- I plan to keep my rescue inhaler and/or epi-pen with me while at school rather than in the school health office. It may not be left unattended in any classroom, student desk, or backpack (exception may be made for locked PE lockers for rescue inhaler)
- I agree to use my rescue inhaler and/or epi-pen in a responsible manner, in accordance with my physician's order.
- I agree to notify the school health aide or other appropriate staff if I am having difficulty with my asthma not relieved by using my rescue inhaler.
- I agree to notify the school health aide or other appropriate staff if I use my epi-pen or am experiencing symptoms of a severe allergic reaction so that 911 can be called immediately.
- I agree to ***NOT ALLOW*** any other person (adult or student) to use my emergency medication.

STUDENT Signature: _____ DATE: _____

- I agree to ensure that my child carries his/her emergency medication as prescribed, and that the medication is in the properly pharmacy labeled container and is not expired.
- I agree / decline to keep recommended back-up emergency medication in the school health office.
- I agree to review the status of my child's health with the District Registered Nurse on a regular basis and as needed to implement this treatment plan.

PARENT Signature: _____ DATE: _____

- The above named student has demonstrated the correct technique for inhaler and/or epi-pen use.
- The above named student verbalized an understanding of following the physician's order for time and dosage for the prescribed medication(s).
- Appropriate district personnel have been notified about the student's medical condition and need to carry emergency medication while at school.

DISTRICT REGISTERED NURSE Signature: _____ DATE: _____