

# COLORADO ASTHMA CARE PLAN AND MEDICATION ORDER FOR SCHOOL AND CHILD CARE SETTINGS

**PARENT/GUARDIAN COMPLETE AND SIGN:**

Child Name: \_\_\_\_\_ School/grade: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_  
 Parent/Guardian Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Healthcare Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Triggers:  Weather (cold air, wind)  Illness  Exercise  Smoke  Dust  Pollen  Other: \_\_\_\_\_  
 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.

	PARENT SIGNATURE	DATE	NURSE/CCHC SIGNATURE	DATE
<b>HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:</b>	QUICK RELIEF (RESCUE) MEDICATION: <input type="checkbox"/> Albuterol <input type="checkbox"/> Other: _____ Common side effects: <input type="checkbox"/> ↑ heart rate, tremor <input type="checkbox"/> Have child use spacer with inhaler. Controller medication used at home: _____			
<b>IF YOU SEE THIS:</b>	<b>DO THIS:</b>			
<b>GREEN ZONE:</b> No Symptoms Pretreat	<ul style="list-style-type: none"> <li>• No current symptoms</li> <li>• Doing usual activities</li> </ul>		Pretreat strenuous activity: <input type="checkbox"/> Not required <input type="checkbox"/> Routine <input type="checkbox"/> Student/Parent request Give QUICK RELIEF MED 10-15 minutes before activity: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> Repeat in 4 hours, if needed for additional physical activity. <b><i>If child is currently experiencing symptoms, follow YELLOW ZONE.</i></b>	
<b>YELLOW ZONE:</b> Mild symptoms	<ul style="list-style-type: none"> <li>• Trouble breathing</li> <li>• Wheezing</li> <li>• Frequent cough</li> <li>• Complains of tight chest</li> <li>• Not able to do activities, but talking in complete sentences</li> <li>• Peak flow: _____ &amp; _____</li> </ul>		<ol style="list-style-type: none"> <li>1. Stop physical activity.</li> <li>2. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs</li> <li>3. Stay with child/youth and maintain sitting position.</li> <li>4. <b>REPEAT</b> QUICK RELIEF MED, if not improving in 15 minutes: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs</li> <li>5. Child/youth may go back to normal activities, once symptoms are relieved.</li> <li>6. Notify parents/guardians and school nurse.</li> </ol> <b><i>If symptoms do not improve or worsen, follow RED ZONE.</i></b>	
<b>RED ZONE: EMERGENCY</b> Severe Symptoms	<ul style="list-style-type: none"> <li>• Coughs constantly</li> <li>• Struggles to breathe</li> <li>• Trouble talking (only speaks 3-5 words)</li> <li>• Skin of chest and/or neck pull in with breathing</li> <li>• Lips/fingernails gray or blue</li> <li>• ↓ Level of consciousness</li> <li>• Peak flow &lt; _____</li> </ul>		<ol style="list-style-type: none"> <li>1. Give QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs                             <ul style="list-style-type: none"> <li>▪ Refer to anaphylaxis plan, if child/youth has life-threatening allergy.</li> </ul> </li> <li>2. Call 911 and inform EMS the reason for the call.</li> <li>3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths.</li> <li>4. Notify parents/guardians and school nurse.</li> <li>5. If symptoms do not improve, <b>REPEAT</b> QUICK RELIEF MED: <input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs every 5 minutes until EMS arrives.  <i>School personnel should not drive student to hospital.</i> </li> </ol>	
<b>PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)</b>				
<input type="checkbox"/> Student needs supervision or assistance to use inhaler. Student will not self-carry inhaler. <input type="checkbox"/> Student understands proper use of asthma medications, and in my opinion, <u>can carry and use his/her inhaler at school independently with approval from school nurse and completion of contract.</u> <input type="checkbox"/> 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 \_\_\_\_\_



## Medication Administration in School or Child Care

The parent/guardian of \_\_\_\_\_ ask that school/child care staff give the  
following medication \_\_\_\_\_ at \_\_\_\_\_  
(Child's name) (Name of medicine and dosage) (Time(s))  
to my child, according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer medication prescribed by a licensed health care provider.  
It is the parent/guardian's responsibility to furnish the medication.

The parent agrees to pick up expired or unused medication within one week of notification by staff.

**Prescription medications** must come in a container labeled with: child's name, name of medicine, time medicine is to be given, dosage, and date medicine is to be stopped, and licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

**Over the counter medication** must be labeled with child's name. Dosage must match the signed health care provider authorization, and medicine must be packaged in original container.

By signing this document, I give permission for my child's health care provider to share information about the administration of this medication with the nurse or school staff delegated to administer medication.

\_\_\_\_\_  
Parent/Legal Guardian's Name

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
Home Phone

\*\*\*\*\*

### Health Care Provider Authorization to Administer Medication in School or Child Care

Child's Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Medication: \_\_\_\_\_

Dosage: \_\_\_\_\_ Route \_\_\_\_\_

To be given at the following time(s): \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Purpose of medication: \_\_\_\_\_

Side effects that need to be reported: \_\_\_\_\_

Starting Date: \_\_\_\_\_

Ending Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Health Care Provider with Prescriptive Authority

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date

*Please ask the pharmacist for a separate medicine bottle to keep at school/child care.*

Thank you!