Asthma Care Plan

Dear Parents/Guardians,

This packet includes an Asthma Care Plan and Contract to Self-Carry a Rescue Inhaler. The information on the completed Care Plan will assist The Classical Academy staff in knowing how to best manage your student's health condition should an emergency arise.

If you and your physician believe your student is able to carry their own inhaler at school, please also complete the Contract to Self-Carry Rescue Inhaler forms. Our health staff recommends a back- up inhaler for students with a self-carry contract on file. You do not need to fill this part out if your student will only have medication in the health room.

The new Asthma Care Plan includes a section that gives Health Services staff permission to administer your student's asthma medications, so a separate Permission to Administer Medications Form is no longer necessary for those medications. However, Academy District Twenty and The Classical Academy policies still require the signature of a health care provider with prescriptive authority, as well as the parent/guardian signature, for all additional medications to be given at school. This includes prescription and over-the- counter medications such as cough drops, Tylenol etc. Each medication requires a separate Permission to Administer Medication form. Forms are available on our website at http://www.tcatitans.org. High School students may carry and self-administer their own medications with the exception of controlled substances, which must be kept in the health room with a completed medication form.

Please fill in the parent portion of the care plan and medication form before giving to your physician f or completion and signature. Submit all forms to your health room before the start of school. **Please be sure to complete all pages of this packet as we cannot accept incomplete Care Plans.**

If you have questions, please feel free to contact the school nurse at your student's campus.

Sincerely,

Your Health Services Team

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

PARENT/GUARDIAN COMPLETE, SIGN AND DATE:

Child Name: _____ Birthdate: _____

School: _____ Grade: _____

Parent/Guardian Name: _____ Phone: _____

I approve this care plan and 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 health care provider. I assume responsibility for providing the school/program prescribed, non-expired medication and supplies (such as a spacer), 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.

_____ _____

Parent/Guardian Signature **Date**

HEALTH CARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:

QUICK RELIEF MEDICATION: ☐ **Albuterol** ☐ **Other:** _____

Common side effects: ↑ heart rate, tremor ☐ **Use spacer with inhaler (MDI)**

Controller medication used at home: _____

TRIGGERS: ☐ **Weather** ☐ **Illness** ☐ **Exercise** ☐ **Smoke** ☐ **Dust** ☐ **Pollen** ☐ **Poor Air Quality** ☐ **Other:** _____

☐ **Life threatening allergy specify:** _____

QUICK RELIEF INHALER ADMINISTRATION: With assistance or self-carry.

☐ 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 **self-carry** and use his/her inhaler at school independently with approval from school nurse and completion of contract.

	IF YOU SEE THIS:	DO THIS:
GREEN ZONE: No Symptoms Pretreat	• No current symptoms • Strenuous activity planned	**PRETREATMENT FOR STRENUOUS ACTIVITY**, please choose **ONE**: ☐ Not required **OR** ☐ Student/Parent request **OR** ☐ Routinely Give **QUICK RELIEF MED** 10-15 minutes before activity: ☐ 2 puffs ☐ 4 puffs Repeat in 4 hours, if needed for additional physical activity. ***If child is currently experiencing symptoms, follow YELLOW or RED ZONE.***
YELLOW ZONE: Mild symptoms	• Trouble breathing • Wheezing • Frequent cough • Chest tightness • Not able to do activities	1. Give **QUICK RELIEF MED:** ☐ 2 puffs ☐ 4 puffs 2. Stay with child/youth and maintain sitting position. 3. **REPEAT QUICK RELIEF MED** if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs ***If symptoms do not improve or worsen, follow RED ZONE.*** 4. Child/youth may go back to normal activities, once symptoms are relieved. 5. Notify parents/guardians and school nurse.
RED ZONE: EMERGENCY Severe Symptoms	• Coughs constantly • Struggles to breathe • Trouble talking (only speaks 3-5 words) • Skin of chest and/or neck pull in with breathing • Lips/fingernails gray/blue	1. Give **QUICK RELIEF MED**: ☐ 2 puffs ☐ 4 puffs ***Refer to the anaphylaxis care plan if the student has a life threatening allergy. If there is no anaphylaxis care plan follow emergency guidelines for anaphylaxis.*** 2. Call 911 and inform EMS the reason for the call. 3. **REPEAT QUICK RELIEF MED** if not improving: ☐ 2 puffs ☐ 4 puffs Can repeat every 5-15 minutes until EMS arrives. 4. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 5. Notify parents/guardians and school nurse.

_____ _____ _____

Health Care Provider Signature **Print Provider Name** **Date**

Good for 12 months unless specified otherwise in district policy.

_____ _____ _____

Fax **Phone** **Email**

_____ _____

School Nurse/CCHC Signature **Date**

☐ Self-carry contract on file. ☐ Anaphylaxis plan on file for life threatening allergy to:

*Including reactive airways, exercise-induced bronchospasm, twitchy airways.

Revised: February 2021

ACADEMY DISTRICT 20/TCA CONTRACT TO

SELF-CARRY **RESCUE INHALER**

This contract is in effect for the current school year only unless revoked by the parent, physician, or school nurse or if the student fails to comply with this contract.

All items must be checked and **all** signatures must be present in order for student to have permission to carry their inhaler with them while at school.

Student Name: _____ Date of Birth: _____

Grade: ____Teacher: _____

If more than one dose is ordered, length of time between dosages of meds to be self-administered: _____

Special instructions/side effects: _____

PHYSICIAN

____ This student has demonstrated the proper use of his/her rescue inhaler.

____ I have instructed the student in the correct and responsible use of the medication.

____ I confirm that the student is capable of administering the prescribed medications.

Physician signature: _____ Date: _____

Office Phone: _____

PARENT

____ My student has demonstrated the proper use of his/her rescue inhaler in my presence.

____ My student understands his/her asthma triggers, symptoms and his/her treatment plan including the difference between when to use preventive medications and his/her rescue inhaler. He/she understands the importance of letting his parents and school staff know when he/she is having more difficulty than usual with his/her asthma.

____ I give permission for my student to keep his/her rescue inhaler with him/her and to self-administer this medication in the school setting.

____ I agree to bring an extra (back-up) rescue inhaler to be kept in the health room.

____ I agree to be responsible for ensuring that both the rescue inhaler my student carries and the back-up inhaler in the health room have medication in them and are not expired.

____ I agree to regularly review with my student the proper use of his/her rescue inhaler to include frequency of use, procedure, and documentation of usage when at school.

____ I agree to regularly review the status of my student's asthma with him/her and his/her physician and to notify said physician when my student is having more difficulty than usual.

____ I agree the school district or school employee is not liable for damages if there is an act of omission related to my student's use of their medication unless the damages were caused by willful or wanton misconduct or disregard of the criteria of the treatment plan.

Parent signature: _____ Date: _____

STUDENT

____ I agree to use my rescue inhaler as prescribed by my doctor above. I understand my asthma triggers, symptoms, and treatment plan including the difference between when to use any preventive medications and my rescue inhaler.

____ I agree to keep my rescue inhaler with me at school as well as an extra one in the health room.

____ I agree to go to the health office when possible to use my rescue inhaler and I agree to always go to the health office to let them know I have used it and to document each time I use my inhaler while at school.

____ I realize it is important for me to let an adult know in the school health office as well as my parents know if I am having more difficulty than usual with my asthma and I agree to tell them.

____ I agree to never share my rescue inhaler with any one.

Student signature: _____ Date: _____

SCHOOL NURSE

____ I agree to notify staff that have the "need to know" about this student's condition and the need to carry a rescue inhaler.

School Nurse Signature: _____ Date: _____

DOES YOUR CHILD HAVE ASTHMA?

☐ **No** – STOP HERE
☐ **Yes** – Please complete this form

If you have any questions, please contact your child's school nurse.
Date form completed:_____ Student ID_____
Student Name: _____ Birth date:_____
Parent/Guardian Name & Phone #:_____
Name of person completing form and relationship (i.e. mom, dad, grandma):_____
Health Care Provider for asthma (name & phone #):_____

1. In the past 12 months, how many times has your child visited the ER/urgent care or had an urgent doctor's office visit for asthma?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

2. In the past 12 months, how many times has your child been hospitalized overnight for asthma?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

3. In the past 12 months, how many times has your child used oral steroids (prednisone, Orapred) to treat an asthma attack?
   ☐ 0 times ☐ 1 times ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

4. How many days of school did your child miss this past school year because of asthma?
   ☐ 0 days ☐ 1-2 days ☐ 3-5 days ☐ 6-10 days ☐ 11-15 days ☐ 15 or more days

5. In the past 4 weeks, how often has your child used a rescue or reliever medicine (a syrup, inhaler, or breathing machine) to relieve coughing, trouble breathing, or wheezing?
   ☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not every day ☐ Every day

6. In the past 4 weeks, how often has your child had coughing, trouble breathing, or wheezing in the morning or during the day?
   ☐ Never ☐ 1-2 days/week ☐ 3 or more days/week but not every day ☐ Every day

7. In the past 4 weeks, how often has your child awakened at night because of coughing, trouble breathing, or wheezing?
   ☐ Never ☐ 1-2 times/month ☐ 3 or more times/month ☐ 2 or more times/week ☐ Every night

8. In the past 4 weeks, how often has your child's asthma bothered or interrupted him/her during normal activities (playing, running around, and sports)?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ All of the time

9. What triggers your child's asthma? (Check all that apply)
   ☐ Illness (colds) ☐ Smoke Allergies: ☐ Cat ☐ Dog ☐ Dust ☐ Mold ☐ Pollen
   ☐ Emotions (crying, laughing, stress) ☐ Exercise/physical activity Food: _____
   ☐ Weather changes ☐ Strong odors/smells Other:_____

10. Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) your child takes for asthma and allergies (the ones every day and as needed) and give the nurse a copy of your written asthma treatment plan.

List Names or Colors of Medicines Used for Asthma	

11. How well does your child take asthma medicines? (Only one answer)
    ☐ Takes medicine by self ☐ Needs help taking medicine ☐ Not using medicine now

Parent Signature_____ Date_____ School Nurse Reviewed_____ Date_____