ASTHMA HEALTH CARE PLAN

Student's Name: _____ **Date of Birth:** _____

School/Grade: _____ **ID #:** _____ **Age when asthma diagnosed:** _____

List all routine daily medications (name of medication, dose, and times given):

_____

_____

_____

TRIGGERS: (Check those which apply to this student)

__Exercise
__Colds (viral illness)
__Weather changes
__Cold air weather changes
__Other _____

__Emotions (when upset)
__Irritants: Chalk dust, dust,
__Molds
__Animal dander -Type:_____

__ cigarette smoke, smog, strong odors (paint, markers, perfumes, sprays)
__Pollens (trees, grasses, and weeds)
__Dust and dust mites

SYMPTOMS OF RESPIRATORY DIFFICULTY: any or all of the following

INTERVENTION: Always treat symptoms even if peak flow is not available.

• Coughing • Chest Tightness • Shortness of Breath •Turning Blue •Wheezing •Rapid, labored breathing
• Pulling in of skin around neck muscles, above collar bone, between ribs and under breast bone
• Difficulty carrying on a conversation due to difficulty breathing • Difficulty walking due to breathing problems
• Shallow, rapid breathing • Blueness (cyanosis) of fingernails and lips • Decreasing or loss of consciousness
• Other _____

Peak flow meter: Yes ___ No ___ Spacer: Yes ____ No ____

CALL 911 IF THE FOLLOWING OCCUR /PERSIST AFTER IMPLEMENTING INTERVENTIONS AS STATED ON THIS ASTHMA HEALTH PLAN

Instructions for Staff:

- Have student stop whatever they are doing
- Send the student to the clinic when experiencing respiratory difficulty as described above

If student has been given permission to self-medicate with their inhaler, allow student to use inhaler according to the following directions:

Directions for self-medication:

_____ (initial if applicable). Signatures of the parent/guardian and the physician(see reverse side) indicate that both agree the above named student has been instructed on proper use of his/her inhaler and is capable of assuming responsibility for using this medication at his/her discretion. Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require a reassessment of the permission to self medicate.

Field Trips:

- Medications and peak flow meter MUST accompany student on all field trips.
- A copy of this Health Care Plan and current phone numbers MUST be with staff member
- Teacher Must be instructed on correct use of asthma medications

(Emergency contact information and Peak Flow Meter Guidelines on reverse side)

ASTHMA HEALTH CARE PLAN

Parents/Guardian: _____
Address: _____ Home Phone: _____ Work Phone: _____

Alternate contacts if parent cannot be reached:
Name: _____ Name: _____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____

Physician who should be called regarding asthma:
Name: _____
Phone: _____ Fax: _____

ASTHMA INTERVENTIONS WITH OR WITHOUT PEAK FLOW METER READINGS

GREEN ZONE - Good control >>>>>>>>>>>>>>

- No cough or wheeze
- Tolerating activity easily

Peak flow **above** _____
Indicates that student's asthma is under good control.
This is where he/she should be every day

Treatment Plan:

1) Daily School Meds: **Circle one**: Albuterol / Other:
_____

2) Use before exercise/physical activity: Yes ___ No ___

3) Other:

YELLOW ZONE - Worsening Asthma > > > > > > >

- Worsening symptoms
- More short of breath with activity
- Need reliever inhaler more often than usual

OR

Peak flow between ____ and _____
Indicates a warning that student's asthma may flare unless additional measures are taken.

Treatment Plan:

1) Reliever inhaler: **Circle one:** Albuterol / Other:
_____

2) Recheck peak flow 10 minutes after treatment
May return to class if symptoms or peak flow improve. Vigorous activity should be avoided.
May repeat inhaler if no improvement in 20 min:
Yes _____ No_____

3) **Call parent** to inform of situation.

4) If student is not improving or getting worse, follow Red Zone plan.

RED ZONE - Danger zone >>>>>>>>>>>>>>

- Getting little relief from inhalers

OR

- Peak flow **below** _____
- More breathless despite increased medications
  Peak flows do not respond to reliever inhaler/nebulizer
  This is student's danger zone.

Treatment Plan:

1) **Call parent** to inform of urgent situation.

2) If symptoms continue to be severe and/or parents aren't available call **911 immediately**

3) **Urgent Medications:** _____
(include dosage)

1) As parent/guardian of _____ , I give permission for this plan to be available for use in my child's school, and for the nurse consultant to contact the above named physician by phone, fax, or in writing when necessary to complete this plan.
2) It is understood by parents and physicians that this plan may be carried out by school personnel other than the school nurse. The school's Registered Nurse is responsible for delegation of this plan to unlicensed school personnel when appropriate.
3) This plan will be reviewed annually and/or whenever the health status or medications change and it is the responsibility of the parent to notify the school nurse of these changes.

Physician Signature: _____ Date: _____
Parent Signature: _____ Date: _____
School Nurse Signature: _____ Date: _____
Student Signature: _____ Date: _____

CONTRACT FOR STUDENTS CARRYING INHALERS WITH THEM WHILE AT SCHOOL

STUDENT

☐ I plan to keep my rescue inhaler with me at school rather than in the school health office.

☐ I agree to use my rescue inhaler in a responsible manner, in accordance with my physician's orders.

☐ I will notify the school health office if I am having more difficulty than usual with my asthma.

☐ I will not allow any other person to use my inhaler.

Student's Signature _____Date _____

PARENT/GUARDIAN

This contract is in effect for the current school year unless revoked by the physician or the student fails to meet the above safety contingencies.

☐ I agree to see that my child carries his/her medication as prescribed, that the device contains medication, and the date is current.

☐ It has been recommended to me that a back-up rescue inhaler be provided to the Health Office for emergencies.

☐ I will review the status of the student's asthma with the student on a regular basis as agreed in the treatment plan.

Parent's Signature _____Date _____

SCHOOL NURSE

☐ The above student has demonstrated correct technique for inhaler use, an understanding of the physician order for time and dosages, and an understanding of the concept of pretreatment with an inhaler prior to exercise.

☐ School staff that has the need to know about the student's condition and the need to carry medication has been notified.

Registered Nurse's Signature _____Date _____