Asthma Packet

For Parent/Guardian

Contents:

- Colorado School Asthma Plan and Medication
- Parent Questionnaire-Colorado School Health Asthma Care Plan, Asthma (or Breathing Problems) information
- Medication Administration in School or Childcare
- Self-Carry Contract

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

PARENT/GUARDIAN COMPLETE AND SIGN:

Child Name: _____ School/grade: _____

Parent/Guardian Name: _____ Birthdate: _____

Healthcare Provider Name: _____ Phone: _____

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

HEALTHCARE PROVIDER COMPLETE ALL ITEMS, SIGN AND DATE:	QUICK RELIEF (RESCUE) MEDICATION: ☐ Albuterol ☐ Other: _____ Common side effects: ↑ heart rate, tremor ☐ Have child use spacer with inhaler. Controller medication used at home: _____
IF YOU SEE THIS:	**DO THIS:**
GREEN ZONE: No Symptoms Pretreat ◦ No current symptoms ◦ Doing usual activities	Pretreat strenuous activity: ☐Not required ☐Routine ☐Student/Parent request 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 ZONE.***
YELLOW ZONE: Mild symptoms ◦ Trouble breathing ◦ Wheezing ◦ Frequent cough ◦ Complains of tight chest ◦ Not able to do activities, but talking in complete sentences ◦ Peak flow: _____ & _____	1. Stop physical activity. 2. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs 3. Stay with child/youth and maintain sitting position. 4. **REPEAT** QUICK RELIEF MED, if not improving in 15 minutes: ☐ 2 puffs ☐ 4 puffs 5. Child/youth may go back to normal activities, once symptoms are relieved. 6. Notify parents/guardians and school nurse. ***If symptoms do not improve or worsen, follow RED ZONE.***
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 or blue ◦ ↓ Level of consciousness ◦ Peak flow < _____	1. Give QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs ▫ Refer to anaphylaxis plan, if child/youth has life-threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Stay with child/youth. Remain calm, encouraging slower, deeper breaths. 4. Notify parents/guardians and school nurse. 5. If symptoms do not improve, **REPEAT** QUICK RELIEF MED: ☐ 2 puffs ☐ 4 puffs every 5 minutes until EMS arrives. *School personnel should not drive student to hospital.*

PROVIDER INSTRUCTIONS FOR QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

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

☐ 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_____

Student Name: _____ Birth date: _____

COLORADO SCHOOL HEALTH ASTHMA CARE PLAN
ASTHMA (OR BREATHING PROBLEMS) INFORMATION FORM

Dear Parent/Guardian: It has come to our attention that your child has asthma or breathing problems. The school nurse needs more information to help us take care of your child at school. Please complete and return this form to school. If you have any questions, please contact your child's school nurse.

Parent/Guardian Name & Phone #: _____

Parent/Guardian Name & Phone #: _____

Other Emergency Contact Name & Phone #: _____

Health Care Provider for asthma & Phone #: _____

1. How much does your child's asthma bother or interrupt him/her during normal activities (playing, running around, and sports)? ☐Never ☐Rarely ☐Sometimes ☐ Often ☐All of the time

2. How many times has your child been had urgent care or hospitalized for asthma in the past year?
   ☐0 times ☐1 time ☐2 times ☐3 times ☐4 times ☐5 or more times

3. a) 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: _____

   b) Does your child have a life threatening allergy or anaphylaxis? ☐ Yes ☐ No
   - If so, does s/he have an epi-pen at school? ☐ Yes ☐ No
   If "yes", complete a Severe Allergy Plan available from the school nurse

4. Describe the symptoms your child typically experiences before or during an asthma episode: (Check all that apply)
   ☐Coughing ☐ Rubbing chin/neck ☐ Clearing the throat ☐Trouble breathing
   ☐ Breathing hard/fast ☐ Feeling tired/weak ☐ Wheezing ☐ Runny nose
   Other _____

5. 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).

List Names or Colors of Medicines Used	

6. How well does your child take his/her asthma medications? (Check only one answer)?
   ☐Takes medicine by self ☐Needs help taking medicine ☐Not using medicine now

7. 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/wk ☐ 3 or more days/wk but not everyday ☐ Everyday

8. 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/wk ☐ 3 or more days/wk but not everyday ☐ Everyday

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

Parent Signature _____ Date _____

School Nurse Review and Additional Information:

Nurse Signature _____ Date _____

Asthma Self Carry Contract **School:** _____ **Grade:** _____

STUDENT : _____ **DOB:** _____

☐ 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 health care plan.

☐ I will provide the school a Health Care Provider signed medication authorization for this medication.

Parent's Signature _____ Date _____

Nurse Consultant _____ **School** _____

☐ 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 have the need to know about the student's condition and the need to carry medication have been notified.

☐ I will review the medication authorization provided by the parent and signed by the health care provider.

Nurse Consultant's Signature _____ Date _____

School Administrator's Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____

Health Assistant Signature: _____ Date: _____

Medication Administration in School or Childcare

The parent/guardian of _____ ask that school/childcare staff give the following
(Child's Name)

medication _____ at _____ to my child,
(Name of medication and dosage) (Time / Times)

according to the Health Care Provider's signed instructions on the lower part of this form.

The Program agrees to administer the medication prescribed by a licensed health care provider. It is the parent/guardian's responsibility to furnish the medication. The parent /guardian agree to pick up the expired or unused medication within one week of notification by staff.

Prescription Medications must come in a container labeled with the child's name, name of medicine, time medicine is to be given, dosage, date medicine is to be stopped and the 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 the child's name. Dosage must match the signed health care provider authorization and medicine must be packaged in its original container.

By signing this document, I hereby 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 Printed Name Parent/Legal Guardian Signature Date

_____ _____ _____
Home Phone Work Phone Cell/Alternate Phone

****

Health Care Provider Authorization to Administer Medication in School or Childcare

(To be completed by licensed health care provider)

Child's Name: _____ Date of Birth: _____

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 with the label to keep at school or childcare. Thank you!!