

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 | ☐ Emotions (when upset) | ☐ cigarette smoke, smog, strong odors (paint, markers, perfumes, sprays) |
| ☐ Colds (viral illness) | ☐ Irritants: Chalk dust, dust, | ☐ Pollens (trees, grasses, and weeds) |
| ☐ Weather changes | ☐ Molds | ☐ Dust and dust mites |
| ☐ Cold air weather changes | ☐ Animal dander -Type: _____ | |
| ☐ Other _____ | | |

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
- 1) **Call**
2) If s
im
3) **Ur**

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:** _____
inhaler (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: _____
 Parent Signature: _____
 School Nurse Signature: _____
 Student Signature: _____

Date: _____
Date: _____
Date: _____
Date: _____