HARTLAND-LAKESIDE SCHOOL DISTRICT

ASTHMA CARE PLAN

Name:	Birth Date:
Teacher:	Grade:
Parent/Guardian:	Preferred Phone:

Triggers: Weather (cold air, wind) Illness Exercise Smoke Dog/Cat Dust Mold Pollen
Other: _____

GREEN ZONE: PRETREAMENT STEPS FOR EXERCISE (health provider please complete section)

☐Give 2 puffs of rescue med (*name)*_____15 minutes before activity (circle indication: Phys Ed, exercise/sport, or recess): Explanation: _____
☐Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK- UNCONTROLLED ASTHMA (health provider complete dosing for rescue med)

IF YOU SEE THIS	DO THIS
-Difficulty breathing -Wheezing -Frequent Cough -Complaints of chest tightness -Unable to tolerate regular activities but still talking in complete sentences -Other:	- Stop physical activity -Give rescue med (name):_____ ☐ 1 puff ☐ 2 puffs ☐via spacer ☐other: _____ -If no improvement in 10-15 minutes, repeat use of rescue med: ☐ 1 puff ☐ 2 puffs ☐via spacer ☐other: _____ -If student's symptoms do not improve or worsen, call 911 -Stay with student and maintain sitting position -Call parents/guardians and school nurse -Students may resume normal activities once feeling better
-If there is **no rescue medication at school**	-Call parent/guardian to pick up student and/or bring inhaler/medication to school -Inform them that if they cannot get to school, 911 may be called

RED ZONE EMERGENCY SITUATION (Health provider complete dosing for rescue medication)

IF YOU SEE THIS:	DO THIS IMMEDIATELY
-cough constantly -struggles or gasps for breath -trouble talking (can speak only 3-5 words) -skin of chest and/or neck pull in breathing -lips or fingernails are gray or blue -↓ level of consciousness	-Give rescue med *(name)*:_____ ☐ 1 puff ☐ 2 puffs ☐via spacer ☐other: _____ -Repeat rescue med if student no improving in 10-15 minutes ☐ 1 puff ☐ 2 puffs ☐via spacer ☐other: _____ -Call 911: Inform attendant the reason for the call is asthma -Call parents/guardians and school nurse -Encourage student to take slower, deeper breath -Stay with student and remain calm *-School personnel should not drive student to the hospital.*

INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX(ES)

- ☐ Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently
- ☐ Student is to notify his/her designated school health officials after using inhaler
- ☐ Student needs supervision or assistance to use his/her inhaler.
- ☐ Student has life threatening allergy needing an Epi-Pen

_____ _____ _____
HEALTH CARE PROVIDER SIGNATURE **PLEASE PRINT PROVIDER'S NAME** **DATE**

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

_____ _____
PARENT SIGNATURE **DATE**