

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: PRETREATMENT 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 ( <i>name</i> ): _____ <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> via spacer <input type="checkbox"/> other: _____ -If no improvement in 10-15 minutes, repeat use of rescue med: <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> via spacer <input type="checkbox"/> 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 <b>no rescue medication at school</b>	-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 ( <i>name</i> ): _____ <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> via spacer <input type="checkbox"/> other: _____ -Repeat rescue med if student no improving in 10-15 minutes <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> via spacer <input type="checkbox"/> 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 - <i>School personnel should not drive student to the hospital.</i>
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**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**