Crivitz School District
HEALTH CARE PLAN FOR THE MANAGEMENT OF ASTHMA

STUDENT_____ **BIRTH DATE**_____

SCHOOL_____TEACHER_____GRADE_____SCHOOL YEAR_____

PARENT/GUARDIAN 1: _____ PARENT/GUARDIAN 2: _____

DAYTIME PHONE: (____)_____ DAYTIME PHONE: (____)_____

CELL: (____)_____ CELL: (____)_____

HEALTH CARE PROVIDER_____ PHONE (____)_____

Asthma History:

Identify the things which trigger an asthma episode (check each that applies to the student).

o Exercise	o Animals	o Molds
o Respiratory infections	o Foods_____	o Pollens
o Changes in temperature	o Strong odors or fumes	o Dust/chalk
o Carpet in room	o Other_____	

Control of School Environment:

List any environmental control measures, pre-medications and /or dietary restrictions that the student needs to prevent an asthma attack.

_____

_____

Emergency Plan:

Emergency Action is necessary when the student has symptoms such as:

o Shortness of breath	o Chest and neck muscles pulling in
o Wheezing (whistling sound while breathing)	o Stoop body posture
o Constant dry hacky cough	o Nasal flaring or grunting
o Trouble talking without breaths between words	o Struggling or gasping
o Severe chest tightness	o Lips and finger beds are grey or blue
o Other	o Other_____

Treatment steps:

1. **Do not leave student unattended.**
2. Follow Asthma Action Plan. Students should respond to treatment in 15 to 20 minutes.
3. Contact parents if:_____.
4. If student is in the Red Zone (child is breathing hard and fast, ribs sticking out, trouble walking, talking or sleeping), call 911 and notify parents/guardians.

Fieldtrips:

Asthma medications/supplies and a copy of the Health Care Plan/Asthma Action Plan will accompany student on all fieldtrips. Students who self-carry their asthma inhalers should be reminded by parent/guardian to carry it on all off school campus activities.

PARENT / GUARDIAN CONSENT

I understand that this Health Care Plan and the Asthma Action Plan will be given to school personnel who work closely with my child. It will remain in effect through the end of the current school year unless changed by me in writing. It is my responsibility to inform supervising staff of my child's health needs if s/he participates in before-school, after-school and extra-curricular programming and to provide the needed emergency medications. I give permission for an exchange of information between school district personnel and the health care provider listed, if necessary, regarding information contained in this Health Care Plan and the Asthma Action Plan.

Parent/Guardian Signature_____ Date_____

Health Services-School Nurse distributed copies to: **FOR SCHOOL USE ONLY**

• Classroom Teacher(s): Date_____ • Art/Phy Ed/Music Teacher: Date_____ • Bus Driver/Sub Driver: Date_____

OTHER _____ Date_____

Emergency Medication will be:

□ Kept in health room/office □ Carried by student and kept in _____ □ Other _____

American Academy of Allergy Asthma & Immunology

Asthma Action Plan for Home & School

Name: _____ Birthdate: _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ He/she has had many or severe asthma attacks/exacerbations

☺ Green Zone

Have the child take these medicines every day, even when the child feels well.

Always use a spacer with inhalers as directed.

Controller Medicine(s): _____

_____

Controller Medicine(s) Given in School: _____

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every four hours as needed

Exercise Medicine: Albuterol/Levalbuterol _____ puffs 15 minutes before activity as needed

😐 Yellow Zone

Begin the sick treatment plan if the child has a cough, wheeze, shortness of breath, or tight chest. Have the child take all of these medicines when sick.

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every 4 hours as needed

Controller Medicine(s):

☐ Continue Green Zone medicines: _____

☐ Add: _____

_____

☐ Change: _____

If the child is in the **yellow** zone more than **24** hours or is getting worse, follow **red** zone and call the doctor right away!

☹ Red Zone

If breathing is hard and fast, ribs sticking out, trouble walking, talking, or sleeping.
Get Help Now

Take rescue medicine(s) now

Rescue Medicine: Albuterol/Levalbuterol _____ puffs every _____

Take: _____

_____

If the child is not better right away, call 911
Please call the doctor any time the child is in the red zone.

Asthma Triggers: (List)

School Staff: Follow the Yellow and Red Zone plans for rescue medicines according to asthma symptoms.
Unless otherwise noted, the only controllers to be administered in school are those listed as "given in school" in the green zone.

☐ Both the asthma provider and the parent feel that the child may carry and self-administer their inhalers
☐ School nurse agrees with student self-administering the inhalers

Asthma Provider Printed Name and Contact Information:	Asthma Provider Signature: Date:

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate. I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor and school-based health clinic providers necessary for asthma management and administration of this medication.

Parent/guardian signature: Date:	School Nurse Reviewed: Date:

Please send a signed copy back to the provider listed above.

American Academy of Allergy Asthma & Immunology
www.aaaai.org

School Supplementary Treatment Orders

(To be Sent with the Asthma Action Plan)

Student Name: _____ **Birthdate:** _____

Asthma Rescue Medications:

See attached **Asthma Action Plan**:

Please follow the treatment plan detailed in the Green zone for activity/exercise treatment and rescue medication plan for Green, Yellow & Red zones, according to asthma symptoms.

Common side effects of albuterol/levalbuterol include increased heart and respiratory rate and jitteriness.

☐ The student may carry and self-administer their inhalers

Pre-activity treatment, including before physical education/recess, should be given:

☐ With all activity ☐ Only when the child or school staff feels he/she needs it

If a Student is in the Red Zone, immediately give their rescue treatment and call 911.
Please follow school emergency plans, according to school/school system policy.

Controller Medications:

Only the following controller or steroid medications should be administered in school:

	AM Dose	PM Dose

If not listed on the Asthma Action Plan:

Triggers:

School specific triggers include: _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

☐ He/she has had many or severe asthma attacks/exacerbations

Please Contact the Asthma Provider listed here with any questions or concerns regarding these orders, or if the student does not have adequate/correct medications in the school.

Asthma Provider Printed Name & Contact Information:

Asthma Provider Signature: **Date:**

Parent/Guardian Permission: I give permission for the medications listed in the Asthma Action Plan to be administered in the school by the nurse or other school members in accordance with school policy. I consent to sharing health information between the prescribing health care provider/clinic, the school nurse, and the school medical advisor necessary for asthma management and administration of this medication.

Parent/guardian signature: **Date:**

For School Use: ☐ School nurse agrees with student self-administering the inhalers

School nurse received/Signature: **Date:**

Please send a signed copy back to the provider at the contact listed above.