

# ≡ ASTHMA HEALTH CARE PLAN ≡

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School/Grade \_\_\_\_\_

**TRIGGERS:** (check those which apply to this student)

- |   |   |
|---|---|
| <input type="checkbox"/> Exercise<br><input type="checkbox"/> Weather changes<br><input type="checkbox"/> Pollens (trees, grasses, and weeds)<br><input type="checkbox"/> Molds<br><input type="checkbox"/> Emotions (excitement, anxiety, tension, depression, grief)<br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> Colds (viral illness)<br><input type="checkbox"/> Cold air<br><input type="checkbox"/> Animal dander - Type: _____<br><input type="checkbox"/> Dust and dust mites<br><input type="checkbox"/> Irritants: chalk dust, dust, cigarette smoke, smog, strong odors (paint, markers, perfumes, sprays) |
|---|---|

**SYMPTOMS & INTERVENTION:** *Always treat symptoms even if peak flow meter is not available.*

- ASTHMA SYMPTOMS:
- |                   |                            |                        |
|-------------------|----------------------------|------------------------|
| • CHEST TIGHTNESS | • SHORTNESS OF BREATH      | • COUGHING (INCESSANT) |
| • WHEEZING        | • RAPID, LABORED BREATHING | • TURNING BLUE         |

**GREEN ZONE - Good control → → → → →**

- No (rare) cough or wheeze
- Tolerating activity easily

AND/OR

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: \_\_\_\_\_

2) Use before exercise/physical activity: \_\_\_\_\_

3) Other: \_\_\_\_\_

**YELLOW ZONE - Worsening Asthma → → →**

- Worsening symptoms noted (see above)
- 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: \_\_\_\_\_

*May repeat \_\_\_ puffs if response not adequate in 20 minutes.*

2) Other: \_\_\_\_\_

3) Recheck peak flow 10 minutes after treatment. May return to class if symptoms or peak flow improve. Vigorous activity should be avoided.

4) **Call parent** to inform of situation.

5) If student is not improving or getting worse, follow Red Zone plan.

**RED ZONE - Danger zone → → → → → → →**

- Getting little relief from inhaler
- More breathless despite increased medications
- Peak flows do not respond to reliever inhaler

OR

Peak flow **below** \_\_\_\_\_.

*This is student's danger zone.*

**TAKE ACTION IMMEDIATELY!!**

**Treatment Plan:**

1) Urgent Meds: \_\_\_\_\_

2) **Call parent** to inform of situation. *If response is poor, parent should be called to come right away.*

3) **If symptoms continue to be severe or response poor:**

A. **Call 9-1-1** immediately.

B. \_\_\_\_\_

C. \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Call 9-1-1 if the following occur:**

- Signs of respiratory distress do not improve with treatment:
  - √ 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 difficulty breathing
  - √ Shallow, rapid breathing
- Blueness (cyanosis) of fingernails and lips
- Decreasing or loss of consciousness

**Field Trips:**

- Medications and peak flow meter should accompany student on all field trips.
- A copy of this Health Care Plan and current phone numbers should be with staff member.

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**EMERGENCY CONTACT INFORMATION**

Father's/Guardian's name: \_\_\_\_\_ Mother's/Guardian's name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Alternate contact person(s) if parent cannot be reached:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**Physician who should be called regarding the asthma episode:**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

**List all routine daily medications (give name, dose, times given):**

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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- 1) As parent/guardian of the above named student, 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 this plan may be carried out by school personnel other than the school nurse. A Registered Nurse is to be responsible for delegation of this plan to an unlicensed person.
- 3) \_\_\_\_\_ (initial if applicable) Signatures of the parent/guardian and the physician 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.

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent signature: \_\_\_\_\_ Date: \_\_\_\_\_

School nurse signature: \_\_\_\_\_ Date: \_\_\_\_\_

School administrator signature: \_\_\_\_\_ Date: \_\_\_\_\_