ASTHMA HEALTH CARE PLAN

Effective Dates:_2025-26 School Year School Fax Number: 517-568-5300

Student's Name: **Date of Birth:**

School/Grade: _____Age when asthma diagnosed: _____List all routine daily medications (name of medication, dose, and times given):

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**

TRIGGERS: (Check those which apply to this student)

__Exercise
__Colds (viral illness)
__Cold air weather changes
__Other_____

___Emotions (when upset)
___Irritants: Chalk dust
___Molds
___Animal dander – Type:_____

____cigarette smoke, smog, strong odors (paint markers, perfumes, sprays)
___Pollens (trees, grasses, weeds)
___Dust and dust mites

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:

__ (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 meters MUST accompany students on all field trips.
A copy of this Health Care Plan and current phone numbers MUST be with staff members.
Teachers MUST be instructed on correct use of asthma medications.

(Emergency contact information and Peak Flow Meter Guidelines on reverse side)

Parents/Guardian:_____
Address:_____ _____ Home Phone: _____Work Phone: _____

Alternate contacts if parent cannot be reached: Name:
Home Phone: : _____
Work Phone: : _____

Name: _____
Home Phone: _____
Work Phone: _____

Physician who should be called regarding asthma:
Name: _____

Phone: _____
Fax: _____

ASTHMA HEALTH CARE PLAN

ASTHMA INTERVENTIONS WITH OR WITHOUT PEAK FLOW METER READINGS

GREEN ZONE - Good control >>>>>>>>>>>>>>	**Treatment Plan:**
• 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	1) Daily School Meds: **Circle one**: Albuterol / Other: _____ 2) Use before exercise/physical activity: Yes ___ No ___ 3) Other:

YELLOW ZONE - Worsening Asthma > > > > > > > Treatment Plan:	
● 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.	1) Allow to step into hallway or go to office to remove mask for a period of time. _____ 2) Use rescue inhaler as ordered. May return to class if symptoms 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 > > > > > > > > > >>>	**Treatment Plan:**
● Getting little relief from inhalers OR ● Peak flow **below _____** ● More breathless despite increased medications ● Peak flows do not respond to reliever inhaler/nebulizer (include dosage) **This is student's danger zone.**	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: _____**

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.
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:		Date:
Parent Signature:		Date
School Nurse Signature:		Date:
Student Signature:		Date: