School District of Jefferson

School Board Policy JHCA-E(6)
Guidelines for Implementation

Photo of child

SCHOOL ASTHMA CARE PLAN

Name:	Birth Date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
Home Phone:	Work Phone:
Other Contact:	Phone:
Preferred Hospital:	

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 class, exercise/sports, 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 medication)

IF YOU SEE THIS:	**DO THIS:**
- Difficulty breathing - Wheezing - Frequent cough - Complains 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 - Student may resume normal activities once feeling better

- If there is **no rescue medication at school**:
  - Call parents/guardians to pick up student and/or bring inhaler/ medications 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:**
- Coughs constantly - Struggles or gasps for breath - Trouble talking (can speak only 3-5 words) - Skin of chest and/or neck pull in with 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 not 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 breaths - Stay with student and remain calm - *School personnel should not drive student to 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. If not self carry, the inhaler is located: _____
☐ Student has life threatening allergy, the Epi-pen® is located: _____

_____ _____ _____
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**

_____ _____ ☐ 504 Plan (or) ☐ IEP
School Nurse Signature Date

Copies of plan provided to: ☐ Teachers ☐ Phys Ed/Coach ☐ Principal ☐ Main Office ☐ Bus Driver
☐ Other: _____