PARENT/GUARDIAN complete and sign the top portion of form.

Student Name:	Birth date:
Parent/Guardian:	Work Phone:
Cell Phone:	Home Phone:
Other Contact:	Phone:
Grade:	Teacher:

Triggers: ☐ Weather (cold air, wind) ☐ Illness ☐ Exercise ☐ Smoke ☐ Dust ☐ Pollen ☐ Other: ______

☐ **Life threatening allergy** : Specify ______

If there is <u>no</u> quick relief inhaler at school and the student is experiencing asthma symptoms:

- 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

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.

☐ 504 PLAN OR IEP

______ PARENT SIGNATURE ______ DATE ______ SCHOOL NURSE SIGNATURE ______ DATE

HEALTH CARE PROVIDER to complete all items, SIGN and DATE completed form.

GREEN ZONE: Student participation in activity and need for pretreatment. No current symptoms.

Pretreatment for strenuous activity: ☐ Not Required

Pretreatment for strenuous activity: ☐ Routinely **OR** ☐ Upon request Explain: (weather, viral, seasonal, other) ______

☐ Give 2 puffs of quick relief med (Check One): ☐ Albuterol ☐ Other: ______ 10-15 minutes before activity.

☐ Repeat in 4 hours if needed for additional or ongoing physical activity.

If student currently experiencing symptoms, follow yellow zone.

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA

IF YOU SEE THIS:	**DO THIS:**
▪ Trouble breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Not able to do activities but still talking in complete sentences ▪ Peak flow between _____ and _____ ▪ Other: ______	1. Stop physical activity 2. GIVE QUICK RELIEF MED: (Check One) ☐ Albuterol ☐ Other: ______ ☐ 2 puffs ☐ Other: ______ 3. Call parents/guardians and school nurse. 4. Stay with student and maintain sitting position. 5. Student may go back to normal activities once feeling better. ***If symptoms do not improve in 10-15 minutes or worsen after giving quick relief medicine, follow RED ZONE plan.***

RED ZONE: EMERGENCY SITUATION – SEVERE ASTHMA SYMPTOMS

IF YOU SEE THIS:	**DO THIS IMMEDIATELY:**
▪ Coughs constantly ▪ Struggles to breathe ▪ Trouble talking (only speaks 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness ▪ Peak flow < ______	1. GIVE QUICK RELIEF MED: (Check One): ☐ Albuterol ☐ Other: ______ ☐ 2 puffs ☐ Other: ______ ☐ Refer to anaphylaxis plan if student has life threatening allergy. 2. Call 911 and inform EMS the reason for the call. 3. Call parents/guardians and school nurse. 4. Encourage student to take slow deep breaths. 5. If symptoms continue, repeat quick relief med: ☐ Albuterol ☐ Other: ______ ☐ 2 puffs ☐ Other: ______ 6. Stay with student and remain calm. 7. If in 20 minutes from first dose, EMS has not arrived and symptoms remain, repeat quick relief medicine (up to 4 more puffs). 8. *School personnel should not drive student to hospital.*

INSTRUCTIONS for QUICK RELIEF INHALER USE: CHECK APPROPRIATE BOX(ES)

☐ Student understands the proper use of his/her asthma medications, and in my opinion, <u>can carry and use his/her inhaler at school independently with approval from school nurse.</u>

☐ Student is to notify his/her designated school health officials after using inhaler.

☐ Student needs supervision or assistance to use his/her inhaler and inhaler will be kept (specify location) ______.

______ HEALTH CARE PROVIDER SIGNATURE ______ PRINT PROVIDER'S NAME ______ PHONE/FAX ______ DATE

Copies of plan provided to: Teacher(s) ___ Phys Ed/Coach ___ Principal ___ Main Office ___ Bus Driver ___ Other ______

Request for Medication Administration at ____________ *School*, Fax--

Required by Colorado law for All *Prescription or Over-the-Counter* Medications

The parent/guardian of (student's name)______________________________ request that the school nurse or medication trained staff give the medication listed below according to the Health Care Provider's signed instructions below.

Per the Colorado Nurse Practice Act, the parent/guardian must:

1. Furnish medicine to the Health Office. Then, pick up expired or unused medication within one week or medication will be disposed. General medications are sent home the last week of school unless it is a controlled substance or an Epi-pen.

2. Prescription and/or Over the counter medication must come *with a doctor's order, parent permission, plus be in the original, non-expired, container. Pharmacy-labeled container* must have the name of the student, the medicine, time to be given, dosage amount, the date medicine is to be stopped, and the licensed health care provider's name. Pharmacy name and phone number must also be included on the label.

3. Sharing of information: By signing this, I give permission for the school health staff to communicate with the health care provider(s), pharmacy, or other appropriate person/clinic re: this student's medical condition or medication (by phone, fax, email, or scan) on issues re: dosing, student's refusal to take meds, side effects, reports of suicidal thoughts, etc. It is understood that the medication is administered solely at the request of & as an accommodation to the undersigned parent or guardian. *Note*: A Health Care Plan may be required to be on file.

4. Release of liability: In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by PCS & it's district, the undersigned parent or guardian hereby agrees to release PCS, its district, and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I hereby give my permission for above student to take the prescription medication as ordered.

____
Parent/Legal Guardian's Printed Name

Grade:____ Teacher: ______________ Ext: ____ RM:____

____
Parent/Legal Guardian's Signature

Home & Cell Phone: ______________________

Email: ______________________ Work Phone: ______________________

Health Care Provider Authorization to Administer Medication at School *(to be filled out by prescribing provider)*

Student: ______________________ **Birth date:** ______________________

Medication (*one per form*):______________________ **Dose:** __________ **Route:**__________

To be given at the following time(s):______________________ **Allergies: Insects Food Unknown Other?:** __________

Condition/Purpose of medication: ______________________ **Special Instructions:** ______________________

Reportable Side effects: ______________________ **Other:** ______________________

NOTE: May Student carry? Yes No May Student 'self-administer'? Yes No

Starting Date: ______________________**Ending Date:** ______________________ **or** ☐ **until end of school year**

Other medications student is on: ______________________

Print HCP Name: ______________________**License Number:** __________ **Office Phone:** __________

Signature of HCP w/ Prescriptive Authority______________________ **Office FAX:** __________

*****Please ask the pharmacist for a separate medicine bottle to keep at school. Thank you!***