SWP Welness_Logo_NoWords**Calhoun County Public Health Department**

**School Wellness Program**

**ASTHMA HEALTH CARE PLAN**

**Effective Dates: 2017-2018 School Year School Fax Number: (269) 729-9648**

**Student’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **School/Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age when asthma diagnosed: \_\_\_\_\_\_\_\_\_\_List all routine daily medications (name of**  **medication, dose, and times given):** |
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| **SYPMTOMS 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 \_\_\_Emotions (when upset) \_\_\_\_cigarette smoke, smog, strong odors (paint

\_\_Colds (viral illness) \_\_\_Irritants: Chalk dust markers, perfumes, sprays)

\_\_Cold air weather changes \_\_\_Molds \_\_\_Pollens (trees, grasses, weeds)

\_\_Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Animal dander – Type:\_\_\_\_\_\_\_ \_\_\_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:

**Directions for self-medication:**

\_\_ (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 meter MUST accompany student on all field trips.
* A copy of this Health Care Plan and current phone numbers MUST be with staff member.
* Teacher MUST be instructed on correct use of asthma medications.

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

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| 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**

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| **GREEN ZONE - Good control >>>>>>>>>>>>>>** | | **Treatment Plan:** |
| • | No cough or wheeze | 1) Daily School Meds: **Circle one**: Albuterol / Other: |
| • | Tolerating activity easily | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * Peak flow **above \_\_\_\_\_\_\_\_** Indicates that student’s asthma is under good control. This is where he/she should be every day | | 2) Use before exercise/physical activity: Yes \_\_\_ No \_\_\_  3) Other: |

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| **YELLOW ZONE - Worsening Asthma > > > > > > > Treatment Plan:** | |
| * Worsening symptoms | 1) Reliever inhaler: **Circle one:** Albuterol / Other:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| * More short of breath with activity * Need reliever inhaler more often than usual   OR | 2) Recheck peak flow 10 minutes after treatment.  May return to class if symptoms or peak flow improve.  Vigorous activity should be avoided.  **May repeat inhaler if no improvement in 20 min:**  Yes \_\_\_\_\_ No\_\_\_\_\_ |
| Peak flow between \_\_\_\_ and \_\_\_\_\_ Indicates a warning that student’s asthma may flare unless additional measures are taken. | 3) **Call parent** to inform of situation. 4) If student is not improving or getting worse, follow Red Zone plan. |

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| **RED ZONE - Danger zone > > > > > > > > >>> Treatment Plan:** | |
| * Getting little relief from inhalers OR | 1) **Call parent** to inform of urgent situation. |
| * Peak flow **below \_\_\_\_\_\_** * More breathless despite increased medications | 2) If symptoms continue to be severe and/or parents aren’t available call **911 immediately** |
| * Peak flows do not respond to reliever inhaler/nebulizer (include dosage)   **This is student’s danger zone.** | 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. The school’s Registered Nurse is responsible for delegation of this plan to unlicensed school personnel when appropriate.

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| 1. 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: |