

Cocke County Schools

Nurse phone #: _____

SCHOOL ASTHMA PLAN AND MEDICATION ORDERS

Place
student
picture
here

Student's Name: _____

Date of Birth: _____

Grade/School: _____

☐ History of anaphylaxis/severe reaction

Bus #: _____

Walk ☐ Drive ☐

PE/Sports: Day/Time/Period: _____

BRIEF MEDICAL HISTORY:

Inhaler(s) is/are located: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER: _____

Epi-Pen(s)® is/are located: ☐ OFFICE ☐ BACKPACK ☐ ON PERSON ☐ OTHER: _____

ALL SECTIONS ON THIS PAGE TO BE COMPLETED BY STUDENT'S LICENSED HEALTHCARE PROVIDER (LHP):

ASTHMA TREATMENT INSTRUCTIONS:

ASTHMA / TRIGGERS: ☐ None Known ☐ Animals ☐ Cold Air ☐ Exercise ☐ Pollens ☐ Respiratory colds
☐ Smoke, chemicals, strong odors ☐ Other _____ (i.e., foods, emotions, insects, etc)

USUAL ASTHMA SYMPTOMS:

☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness ☐ Asking to use inhaler ☐ Other _____

GO ZONE (GREEN)

INFREQUENT/MINIMAL SYMPTOMS

- Symptoms and/or use of quick relief medication \leq 2 times a week. (Does not include exercise pre-treatment usage.)
Infrequent and minimal symptoms like cough, wheeze, short of breath.
- Full participation in physical education and sports

CAUTION ZONE (YELLOW)

SIGNIFICANT SYMPTOMS

DO NOT LEAVE STUDENT UNATTENDED

- If Student is using the quick relief inhaler > 2 times a week or requires frequent observation by school staff → **Notify parents/nurse**
- **If Student is coughing, wheezing, and having difficulty breathing:**
☐ Give 2 puffs of quick relief inhaler. May repeat in 10 minutes. If doesn't recover to Green Zone → **Notify parents/nurse if repeated.**
☐ Other: _____
- Until symptoms are in the GO (green) ZONE, restrict strenuous physical activity.
- If no improvement after repeated dose **Call 911—See below**

STOP ZONE (RED)

CALL 911

DO NOT LEAVE STUDENT UNATTENDED

If Student is very short of breath, can see ribs during breathing, difficulty walking or talking, blue appearance to lips or nails, quick relief medication not working.

➤ **Call 911**

- ☐ Give 4 puffs quick relief inhaler (or nebulizer treatment) and notify parents and school nurse.
- ☐ This student needs Epi-Pen® for severe asthma attacks and ☐ can carry & self administer Epi-Pen® ☐ needs help giving the Epi-Pen®.
- ☐ Other: _____

EXERCISE PRE-TREATMENT: (check all that apply) ☐ N/A

- ☐ Give 2 puffs of quick relief inhaler 15- 30 minutes prior to recess ☐ / physical education ☐
- ☐ May repeat 2 puffs of quick relief inhaler if symptoms recur. **Notify Nurse & Parent if occurs.**

Quick relief medication orders: (check the appropriate quick relief med) ☐ Uses inhaler with spacer

- ☐ Albuterol 2 puffs (Pro-air®, Ventolin HFA®, Proventil®) as needed every 4 hours for cough/wheeze
- ☐ Levalbuterol 2 puffs (Xopenex®) as needed every 4 hours for cough/wheeze
- ☐ Other (i.e., ☐ EpiPen® ☐ EpiPen, Jr.® / Nebulizer): _____

Daily Controller meds: _____

- ☐ Takes daily controller medications at home ☐ Takes daily controller medications at school Which meds and time _____

SIDE EFFECTS of medication(s): _____

☐ This student demonstrated correct use of the inhaler to the LHP. This student is able to carry & use inhalers by himself/herself. ☐ YES ☐ NO

Start date: _____

End date: (not to exceed current school year) _____

☐ Last day of school

Other: _____

LHP Signature: _____

Print Name: _____

Date: _____

Telephone #: _____

Fax#: _____