

#3b ASTHMA CARE PLAN FOR EAGLE'S NEST OWL'S ROOST ENVIRONMENTAL DAY CAMP



Photo of child

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:
<ul style="list-style-type: none"> <li>▪ Difficulty breathing</li> <li>▪ Wheezing</li> <li>▪ Frequent cough</li> <li>▪ Complains of chest tightness</li> <li>▪ Unable to tolerate regular activities but still talking in complete sentences</li> <li>▪ Other:</li> </ul>	<ul style="list-style-type: none"> <li>▪ Stop physical activity</li> <li>▪ Give rescue med (<i>name</i>): _____  <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> other: _____</li> <li>▪ If no improvement in 10-15 minutes, repeat use of rescue med:  <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> other: _____</li> <li>▪ If student's symptoms do not improve or worsen, call 911</li> <li>▪ Stay with student and maintain sitting position</li> <li>▪ Call parents/guardians and school nurse</li> <li>▪ Student may resume normal activities once feeling better</li> </ul>
<ul style="list-style-type: none"> <li>▪ If there is <b>no rescue medication at school</b>:                             <ul style="list-style-type: none"> <li>➢ Call parents/guardians to pick up student and/or bring inhaler/ medications to school</li> <li>➢ Inform them that if they cannot get to school, 911 may be called</li> </ul> </li> </ul>	

**RED ZONE: EMERGENCY SITUATION** (Health provider complete dosing for rescue medication)

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
<ul style="list-style-type: none"> <li>▪ Coughs constantly</li> <li>▪ Struggles or gasps for breath</li> <li>▪ Trouble talking (can speak only 3-5 words)</li> <li>▪ Skin of chest and/or neck pull in with breathing</li> <li>▪ Lips or fingernails are gray or blue</li> <li>▪ ↓ Level of consciousness</li> </ul>	<ul style="list-style-type: none"> <li>▪ Give rescue med (<i>name</i>): _____  <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> Other: _____</li> <li>▪ Repeat rescue med if student not improving in 10-15 minutes  <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Via spacer <input type="checkbox"/> Other: _____</li> <li>▪ Call 911 Inform attendant the reason for the call is asthma</li> <li>▪ Call parents/guardians and school nurse</li> <li>▪ Encourage student to take slower deeper breaths</li> <li>▪ Stay with student and remain calm</li> <li>▪ <i>School personnel should not drive student to hospital</i></li> </ul>

**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 epipen 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 \_\_\_\_\_

Camp Nurse Signature \_\_\_\_\_ DATE \_\_\_\_\_  504 Plan or IEP

Copies of plan provided to: Supervisor \_\_\_\_\_ Camp Coordinator \_\_\_\_\_