Science Discovery
UNIVERSITY OF COLORADO **BOULDER**

Asthma Care Plan

Please Note: This form should only be completed if your child suffers from asthma and has been prescribed and inhaler.

This form WILL NOT be accepted without a physician's signature.

****THIS FORM IS DUE 30 DAYS PRIOR TO THE START OF YOUR CHILD'S PROGRAM****

Student's Name: _____ Birthdate: _____

Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

Child's Camp Name(s) and Start Date(s):_____

_____

Triggers for Asthmatic Attacks (Check those that apply)

☐Weather changes ☐Illness ☐Pollen ☐Dust ☐Smoke ☐Exercise ☐Animal dander
☐Strong odors ☐Mold ☐Other: _____

For Sick/Uncontrolled Asthma

—Difficulty breathing
—Wheezing
—Frequent cough
—Complains of chest tightness
—Unable to tolerate regular activities but still talking in complete sentences
—Other: _____

Treatment

1. Stop current activity.
2. Give rescue med (Name): _____
   ☐1 puff ☐2 puffs ☐Via spacer ☐Other: _____
3. If no improvement in 10-15 minutes, repeat use of rescue med:
   ☐1 puff ☐2 puffs ☐Via spacer ☐Other: _____
4. Encourage student to maintain sitting position.
5. Contact parent/guardian or emergency contact.
6. Student may resume normal activities once feeling better.

For Emergency Situations

—Coughs constantly
—Struggles or gasps for breath
—Lips or fingernails are grey or blue
—Trouble talking (can only speak 3-5 words)
—Skin of chest and/or neck pulls in with breathing
—Decreased level of consciousness

Treatment

1. Give rescue med (Name): _____ **(ensure medication is not expired)**
   ☐1 puff ☐2 puffs ☐Via spacer ☐Other: _____
2. If no improvement in 10-15 minutes, repeat use of rescue med:
   ☐1 puff ☐2 puffs ☐Via spacer ☐Other: _____
3. Call 911 and state that reason for call is asthma.
4. Call parent/guardian or emergency contact.
5. Stay with student and encourage student to take slower deeper breaths.

Instructions for Rescue Inhaler Use: (Please Check Appropriate Box)

☐Student understands proper use of his/her asthma medications, and can carry and self-administer his/her inhaler while at CU Science Discovery.

☐Student needs supervision or assistance to use his/her inhaler (If this is the case, the inhaler will be stored with child's instructor or teaching assistant.).

Please Note: Student is to notify his/her instructor and/or teaching assistant after using inhaler.

Health Care Provider Information

(Physician's signature indicates that a healthcare provider has approved this child to receive the indicated medication and/or that the child is able to self-administer.)

_____ _____

Physician's Name (Please Print) License Number

_____ _____

Physician's Signature and Title Phone Number
(A stamp is acceptable if title is present)

It is understood that the medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. The undersigned parent or guardian hereby agrees to release, defend, and indemnify the Regents of the University of Colorado, a body corporate, CU Science Discovery, and its officers, employees, and agents, from any legal claims arising out of the administration of (or failure to administer) the medications specified above. The undersigned parent or guardian understands that the University and CU Science Discovery are not responsible for the administration of any medication and will not administer medications other than those specified in the student's Asthma Care Plan.

I give permission for CU Science Discovery personnel to share this information, follow this plan, administer medication, care for my student and, if necessary, contact the student's health care provider. I assume full responsibility for providing CU Science Discovery with prescribed medication and/or delivery/monitoring devices. I approve this Asthma Care Plan for my student.

_____ _____

Parent/Guardian Signature Date