

CLEVELAND CITY SCHOOLS ASTHMA HEALTH CARE PLAN

<u>Name:</u>		<u>Grade:</u>
Age:	School:	
What Triggers Asthma problems:		
<p style="text-align: center;"><u>GREEN - MAINTENANCE</u></p> <ul style="list-style-type: none"> - Breathing is good - No coughing or wheezing - Can work & play <p style="text-align: center;">Peak Flow Number _____ to _____</p>	<p><u>Medication & Dose:</u></p> <p>_____</p> <p>_____</p> <p><u>When to give:</u></p> <p>_____</p> <p>_____</p>	
<p style="text-align: center;"><u>YELLOW – CAUTION</u></p> <ul style="list-style-type: none"> - Coughing - Wheezing - Tight chest <p style="text-align: center;">Peak Flow Number _____ to _____</p>	<p><u>Medication & Dose:</u></p> <p>_____</p> <p>_____</p> <p><u>When to give:</u></p> <p>_____</p> <p>_____</p>	
<p style="text-align: center;"><u>RED - DANGER</u></p> <ul style="list-style-type: none"> - Medicine is not helping - Breathing is hard & fast - Nose opens wide - Can't talk well or walk <p style="text-align: center;">Peak Flow Number _____ to _____</p>	<p><u>Medication & Dose:</u></p> <p>_____</p> <p>_____</p> <p><u>When to give:</u></p> <p>_____</p> <p>_____</p> <p style="text-align: center;"><u>DON'T HESITATE TO CALL 911</u></p>	
<u>Health Plan:</u>		
<u>Parent agrees to notify school nurse of any changes in treatment plan.</u>		
<u>Other health concerns:</u>		
<u>Additional Medications:</u>	<u>Dose/Time:</u>	
<u>Dietary concerns/restrictions:</u>		
<u>Parent Signature*:</u>		<u>Date:</u>

* signatures required	
Contact Information:	
Address:	
Parent/Guardian:	Home phone:
1. _____	Work: _____ Cell: _____
2. _____	Work: _____ Cell: _____
Emergency contact:	Phone:
Primary Care Physician:	Phone:
Speciality MD:	Phone:
School Nurse:	Phone: