Health Office
School Nurse

Kristin Denning, RN BSN.
AISD Head Nurse

Joolan Eom, RN
AISD Assistant Nurse

Plan effective for school year:

ASTHMA—Emergency Care Plan

Is this condition potentially life threatening? Yes ___ NO ___
Never send a student with asthma symptoms anywhere alone !

Grade: DOB:

Student Name:

Student Photo

Parent/Guardian:	Home:	Work:
	Cell:	
	Home:	Work:
	Cell:	
Emergency Contact:		Phone:
Physician:	Phone:	

Current Medication: **Allergies:**

Triggers:

SYMPTOMS of an ASTHMA ATTACK

MILD	MODERATE	SEVERE
Cough **Difficulty Breathing**	**Chest tightness** **Difficulty breathing** **Unusual sounds with breathing (wheezing)** **Anxious** **Nostrils flaring** **Shoulders hunched over**	**Lip, nails or mucous membranes are pale, gray or bluish** **Rapid pulse (over 120per minute)** **Gasping breaths (over 30per minute)** **Chest and neck ”pulling in’ with breathing** **Severe restlessness** **Unable to speak in complete sentences without taking a breath** **Decreasing or loss of consciousness**

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IF YOU SEE THIS	DO THIS **Never send an asthmatic student anywhere alone!!**	TIME Initials
Mild or Moderate signs	**Medication Located:_____** **If unable to go to health office, have meds brought to student if necessary (Call school nurse). Sit student in an upright position, if conscious offer water. Instruct to breathe in through nose and out through pursed lips slowly and deeply. Check time of last medication. Give _____ by inhaler or nebulizer _____hours apart. Assist student to inhale medication slowly and fully.**	
NO IMPROVEMENT WITHIN 15 MINUTES after medication	**Notify Parents /guardians**	
SEVERE SYMPTOMS	**Call School nurse at 01713396612, Call parents**	
BREATHING STOPS	**Call United ambulance at 10666, Begin CPR**	
Note time of arrival and departure of ambulance; send a copy of form with the ambulance.		

A copy of this plan will be kept in the school office and copies will be given to bus and PE/athletic department staff/transportation/music/library/recess .The following staff have been trained to deal with an emergency, and initiate the appropriate procedures as described above. Signature by parent indicates agreement with this plan.

1. _____ 2. _____ 3. _____
5. _____ 6. _____
4. _____

_____ _____ _____
School Nurse Date Parent Signature Date Physician Signature Date