PEASTER ISD
SCHOOL HEALTH PROGRAM

EMERGENCY ASTHMA PLAN

Student:_____DOB:_____ Grade_____

Parent:_____Phone:(H)_____(W)_____

Second Contact Person: _____Phone: _____

Physician:_____Phone: _____

Common Asthma Attack Signs and Symptoms:

Persistent coughing Wheezing while breathing in or out Shortness of breath Tightness in chest

Emergency Asthma Medications:

Medication Name	Dose	Frequency
1. _____	_____	_____
2. _____	_____	____ _____

***If a student has asthma symptoms or complaints and needs your assistance, take these steps ***

- **Quickly evaluate** the situation. **Call 911** if the student is **struggling to breathe, talk, stay awake, has blue lips or asks for an ambulance.**
- **NEVER LEAVE A STUDENT ALONE.** Have an adult accompany the student to the health clinic or send for help. **Do not wait.**
- **Stop the student's activity.** If the episode began after exposure to an allergen or irritant, remove the student from the allergen or irritant, if possible. Help the student stay calm and in a comfortable upright position.
- **Help the student locate and take his/her prescribed quick relief inhaler**

*****Contact parent if medication did not relieve symptoms*****

CALL 911 NOW FOR:

- Rapid, labored breathing
- "Pulling in" of neck and chest with breathing (retracting)
- Unable to talk in full sentences
- Nasal flaring
- Sweaty, clammy skin, gray- bluish discoloration around mouth

AND GIVE EMERGENCY MEDICATIONS LISTED

Additional Orders:

Authorization for Self Carry / Self Administration of Inhaler

In my professional opinion, the student should be allowed to carry the prescribed inhaler on his/her person and self administer medication. I believe that the student is competent in his/her known asthma and is able to perform the medication administration technique properly.

_____ (Physician Initials)

I, the parent/guardian am requesting that my child be allowed to keep the prescribed inhaler on his/her person at all times and be able to self administer medication as needed and as directed by the physician. I understand that it is the student's responsibility to keep the inhaler on his/her person. If the inhaler is misplaced or used by other students, this privilege may be revoked. I also understand that the inhaler must have a proper prescription label.

_____ (Parent Initials)

I give permission for the school nurse to consult with the above named physician, and obtain needed information regarding my child's health condition and medications as it pertains to my child's health and safety

_____ _____
Physician Signature Date

_____ _____
Parent's Signature Date

_____ _____
Nurse's Signature Date

_____ _____
Nurse Aide Signature Date