EMERGENCY CARE PLAN – ASTHMA

Student Name _____Birthdate_____Grade/Teacher_____

School Name_____ School Year_____

Severity Classification
□ Intermittent
□ Mild
□ Moderate
□ Severe

Triggers
□ Colds □Smoke □Weather
□ Exercise □ Dust □ Animals
□ Air Pollution □ Foods
□ Other_____

If your child requires medication at school, you must have a **Prescription Medication Permission Form** signed by doctor and parent on file **BEFORE** the medication can be given.

Green Zone: Child is Doing Well

Symptoms:
- Breathing is good
- No cough or wheeze
- Can work and play
- □ Other_____

Peak Flow Meter
More than 80% of _____Personal best _____

Care at School
- Monitor student for asthma symptoms
- Monitor environment for triggers
- □ Other_____

Yellow Zone: Child is Getting Worse

Symptoms may include one or more:
- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Short of breath
- □ Other_____

Peak Flow Meter
_____to _____
(50 to 79% of personal best peak flow)

Care at School
- Give reassurance and do not leave student alone
- Allow time to rest sitting upright
- Have student breath slowly in through nose and out through mouth
- □ Administer medication(s)
  Name_____
  Backpack Desk Health Office
  Locker#_____ Gym Locker #_____
- □ Other_____

Red Zone: Medical Alert

Symptoms may include one or more:
- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping
- Lips, tongue or fingernails turning blue
- Appears sleepy/drowsy during attack
- □ Other_____

Peak Flow Meter
_____to _____
(Less than 50% of personal best peak flow)

Care at School
- **Call 911 immediately**
- Give reassurance and do not leave student alone
- Have student sit upright and breath in through nose and out through mouth
- □ Administer medication(s)
  Name_____
  Backpack Desk Health Office
  Locker#_____ Gym Locker #_____
- No pulse and/or breathing–**Start CPR immediately**
- **Call parent**
- □ Other_____

Continued on Back

INDIVIDUALIZED HEALTH CARE PLAN – ASTHMA CONTINUED

Student Name _____

1. When was your child diagnosed with asthma?_____
2. Does your child take medications for asthma? □ Yes □ No
    a. If yes, name of medication(s) and dose _____
    b. Time(s) of day medication(s) are taken_____
3. Does your child need help using asthma medications? □ Yes □ No
4. Can your child identify his/her asthma signs and symptoms that indicate the need for help or medical attention? □ Yes □ No
5. What additional information will help school staff understand your child's asthma plan?

_____

_____

We recommend that students with asthma wear a Medic-Alert bracelet/pendant at all times.

School Nurse Signature_____Date Reviewed_____