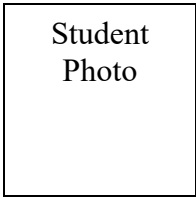




PLEASANT VALLEY SCHOOL DISTRICT
Health Services Department
ASTHMA EMERGENCY CARE PLAN



To be completed by Parent/Guardian

Name: _____ Date of Birth: _____ Grade: _____
 School: _____ Teacher: _____
 Parent/Guardian Name: _____ Phone (Home/Work/Cell): _____
 Parent/Guardian Name: _____ Phone (Home/Work/Cell): _____

To be completed by Health Care Provider

Health Care Provider: _____ Phone: _____

Asthma severity (circle one): Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

A completed and signed Authorization for all Medication Taken During School Hours, School Activities, and Field Trips (SFA-5010) form for each medication prescribed on this Asthma Emergency Care Plan is on file for this school year.

1. Control medication to be taken at school: _____
 2. Quick-relief medication when symptoms occur at school: _____
 3. Preventive medication before exertion or exercise at school: _____

 If student requires an inhaler before exercise how many minutes before exercise: _____

4. For students on inhaled medication (all students must go to the health office for oral medications):
 Assist student with medication in health office Student may carry own inhaled medication

5. Check known triggers:

<input type="checkbox"/> Exercise	<input type="checkbox"/> Paint	<input type="checkbox"/> Grass	<input type="checkbox"/> Strong odors
<input type="checkbox"/> Cold weather	<input type="checkbox"/> Smoke	<input type="checkbox"/> Perfume	<input type="checkbox"/> Weather changes
<input type="checkbox"/> Chalk dust	<input type="checkbox"/> Flowers	<input type="checkbox"/> Mold	<input type="checkbox"/> Food
<input type="checkbox"/> Dust Mites	<input type="checkbox"/> Bushes	<input type="checkbox"/> Animal/Birds	<input type="checkbox"/> Allergies
<input type="checkbox"/> Air Pollution	<input type="checkbox"/> Trees	<input type="checkbox"/> Pollens	<input type="checkbox"/> Other

ACTION TO TAKE	CALL 911 IF STUDENT HAS
<ul style="list-style-type: none"> Stay with Student, remain calm and speak softly Seat student in upright position Encourage slow and deep breaths Give quick-relief medication: shake well before each puff, give _____ puffs (hold breath for 10 seconds after inhaling medication and wait 1 minute between puffs) 	<ul style="list-style-type: none"> Difficulty speaking Flared or enlarged nostrils Rapid or shallow breathing Struggling or gasping for breath Continuous spasmodic coughing Skin pulling in around neck with breathing Gray, dusky or bluish color around mouth or under finger nails

Administer CPR if Breathing Stops! Continue Until EMS Arrive!

I authorize school personnel to implement this Asthma emergency Plan as described:

_____ Health Care Provider Signature	_____ Date
I give my consent for school personnel to take appropriate action for the safety and welfare of my child. I give my consent for the school nurse to communicate with the authorized health care provided when necessary.	
_____ Parent/Guardian Signature	_____ Date

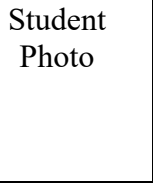


DISTRITO ESCOLAR PLEASANT VALLEY

Departamento de Servicios de Salud

PLAN DE CUIDADO DE EMERGENCY PARA ASMA

Para ser llenado por un Padre/Tutor



Nombre: _____ FdeN _____ Grado: _____

Escuela _____ Maestro: _____

Nombre de Padre/Tutor: _____ Tel. (casa/trab./Cell): _____

Nombre de Madre/Tutor: _____ Tel. (casa/trab./Cell): _____

To be completed by Health Care Provider

Health Care Provider: _____ Phone: _____

Asthma severity (circle one): Mild Intermittent Mild Persistent Moderate Persistent Severe Persistent

A completed and signed Authorization for all Medication Taken During School Hours, School Activities, and Field Trips (SFA-5010) form for each medication prescribed on this Asthma Emergency Care Plan is on file for this school year.

1. Control medication to be taken at school: _____

2. Quick-relief medication when symptoms occur at school: _____

3. Preventive medication before exertion or exercise at school: _____

 If student requires an inhaler before exercise how many minutes before exercise: _____

4. For students on inhaled medication (all students must go to the health office for oral medications):
 Assist student with medication in health office Student may carry own inhaled medication

5. Check known triggers:

<input type="checkbox"/> Exercise	<input type="checkbox"/> Paint	<input type="checkbox"/> Grass	<input type="checkbox"/> Strong odors
<input type="checkbox"/> Cold weather	<input type="checkbox"/> Smoke	<input type="checkbox"/> Perfume	<input type="checkbox"/> Weather changes
<input type="checkbox"/> Chalk dust	<input type="checkbox"/> Flowers	<input type="checkbox"/> Mold	<input type="checkbox"/> Food
<input type="checkbox"/> Dust Mites	<input type="checkbox"/> Bushes	<input type="checkbox"/> Animal/Birds	<input type="checkbox"/> Allergies
<input type="checkbox"/> Air Pollution	<input type="checkbox"/> Trees	<input type="checkbox"/> Pollens	<input type="checkbox"/> Other

ACTION TO TAKE	CALL 911 IF STUDENT HAS
<ul style="list-style-type: none"> Stay with Student, remain calm and speak softly Seat student in upright position Encourage slow and deep breaths Give quick-relief medication: shake well before each puff, give _____ puffs (hold breath for 10 seconds after inhaling medication and wait 1 minute between puffs) 	<ul style="list-style-type: none"> Difficulty speaking Flared or enlarged nostrils Rapid or shallow breathing Struggling or gasping for breath Continuous spasmodic coughing Skin pulling in around neck with breathing Gray, dusky or bluish color around mouth or under finger nails

Administer CPR if Breathing Stops! Continue Until EMS Arrive!

Autorizo al personal escolar a implementar el Plan de Emergencia para Asma. El plan descrito:

_____	_____
Health Care Provider Signature	Date
Le doy mi consentimiento al personal escolar a tomar acción apropiada para la seguridad y bienestar de mi niño. Doy mi consentimiento a la enfermera escolar para que se comunique con el proveedor de cuidado de salud autorizado cuando sea necesario.	
_____	_____
Firma de uno de los padres/tutor	Fecha