PLEASANT VALLEY SCHOOL DISTRICT
Health Services Department

# ASTHMA EMERGENCY CARE PLAN

Student Photo

## 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:

| | | | |
|---|---|---|---|
| ❑ Exercise | ❑ Paint | ❑ Grass | ❑ Strong odors |
| ❑ Cold weather | ❑ Smoke | ❑ Perfume | ❑ Weather changes |
| ❑ Chalk dusk | ❑ Flowers | ❑ Mold | ❑ Food |
| ❑ Dust Mites | ❑ Bushes | ❑ Animal/Birds | ❑ Allergies |
| ❑ Air Pollution | ❑ Trees | ❑ Pollens | ❑ Other |

| ACTION TO TAKE | CALL 911 IF STUDENT HAS |
|---|---|
| • Stay with Student, remain calm and speak softly<br>• Seat student in upright position<br>• Encourage slow and deep breaths<br>• 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) | • Difficulty speaking<br>• Flared or enlarged nostrils<br>• Rapid or shallow breathing<br>• Struggling or gasping for breath<br>• Continuous spasmodic coughing<br>• Skin pulling in around neck with breathing<br>• 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

Student Photo

**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:

| | | | |
|---|---|---|---|
| ❑ Exercise | ❑ Paint | ❑ Grass | ❑ Strong odors |
| ❑ Cold weather | ❑ Smoke | ❑ Perfume | ❑ Weather changes |
| ❑ Chalk dusk | ❑ Flowers | ❑ Mold | ❑ Food |
| ❑ Dust Mites | ❑ Bushes | ❑ Animal/Birds | ❑ Allergies |
| ❑ Air Pollution | ❑ Trees | ❑ Pollens | ❑ Other |

| ACTION TO TAKE | CALL 911 IF STUDENT HAS |
|---|---|
| • Stay with Student, remain calm and speak softly<br>• Seat student in upright position<br>• Encourage slow and deep breaths<br>• 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) | • Difficulty speaking<br>• Flared or enlarged nostrils<br>• Rapid or shallow breathing<br>• Struggling or gasping for breath<br>• Continuous spasmodic coughing<br>• Skin pulling in around neck with breathing<br>• 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