



RYE CITY SCHOOL DISTRICT
Rye, New York 10580

Place
Child's
Picture
Here

**ASTHMA
EMERGENCY HEALTH CARE PLAN**

Name of Student: _____ D.O.B: ____/____/____ Grade: _____

High risk for severe reaction: **Yes** **No** (check one)

SYMPTOMS:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath, and respirations greater than 22/minute
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, difficulty in walking/talking
- **APPEARS:** anxious, sweating, nauseous, fatigued, gasping for air, the use of neck muscles when breathing
- **RAPID PULSE:** greater than 120/minute
- Other - _____

- * **Stop activity immediately**
- * **Help student assume a comfortable position (sitting up is usually more comfortable)**
- * **Notify school nurse**

STEP 1: TREATMENT (To be determined by physician)

Inhaler Order: _____
Medications/Dose/Route/Frequency/Indication

Authorization for Self-Directed (Inhaler Only): **Yes** **No** (check one)

He/she is self-directed, has been instructed in the procedure of self-administration and can assume responsibility for carrying his/her own properly labeled medication in the original container. He/she understands the purpose, the correct dose, the possible side effects, and the frequency of use. I request that he/she be permitted to carry his/her own medication, including Field Trips, or to keep own medication in his/her locker. The School Nurse has final approval.

Doctor's Signature: _____ Date: _____
(Required)
Address: _____ Phone: _____

STEP 2: EMERGENCY ACTION

1. Give medication as prescribed under Step 1: Treatment.
2. CALL AMBULANCE: 911 (Police: (914) 967-1234). Worsening symptoms after initial treatment.
3. CALL PARENT/GUARDIAN: _____

I request that my child receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I give permission for my child to receive the prescribed medication as directed and under the supervision of the school nurse or designated other.

Parent/Guardian Signature: _____ Date: _____