NAME:_____

ASTHMA
EMERGENCY ACTION PLAN

SYMPTOMS: Difficulty breathing with short inhalations and longer exhalations, rapid, shallow breathing, wheezing (high-pitched noise heard with breathing), excessive coughing (may cause vomiting), sensation of chest tightness, flaring of nostrils, tingling/numbness in fingers/toes, loss of color in lips.

INTERVENTIONS:

1. Attempt to calm student. Stay with student.
2. Have student rest in a sitting position, breathing slowly through mouth, exhaling slowly through pursed lips.
3. Offer fluids.
4. Have student take prescribed medication as ordered by health care provider and parent.
5. Notify school nurse if in building.
6. Notify parent of severe breathing difficulty or if medication is not effective in 15 minutes.
7. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to _____Hospital.
8. Additional information:

In order to make sure my child's special health needs are met, I understand and agree that the information will be shared with school staff/other personnel on a need to know basis in order to provide appropriate care. I understand and agree that the school nurse may contact my child's doctor about this condition.

PARENT/GUARDIAN SIGNATURE_____DATE_____

NURSE_____ DATE_____

SCHOOL ASTHMA RECORD

NAME OF STUDENT _____SCHOOL_____

GRADE/TEACHER_____YEAR_____

PARENT/GUARDIAN_____PHONE_____

_____PHONE_____

HEALTH CARE PROVIDER_____PHONE_____

1. Does your child wear a "medic alert" bracelet? ¡Yes ¡ No

2. Briefly describe what causes your child's asthma symptoms (weather, cold, allergies, exercise):

3. How often does the child have a bad enough asthma attack that he/she needs to see a health care provider or go to the hospital?

4. Does your child have an Asthma Action Plan from their doctor? n Yes o No
(A copy of the plan must be provided to the school)

5. Name any medication that your child takes for his/her asthma (how often and how much):

At Home?

At School?

6. Does your child suffer any side effects from these medications? Please list them:

7. Name any activities/exercise in which your child CANNOT participate. (DOCTOR'S NOTE REQUIRED)

8. What does your child do at home to relieve their symptoms during an asthma attack? Please check all that apply)

__ Breathing exercises

__Rest/relaxation

__Drinks liquids

Takes medicine: __ Inhaler

__ Nebulizer

__ Oral medicine

PLEASE NOTE: If medications are to be taken at school, they must have a prescription label from the doctor, and a medical authorization for must be completed by the doctor and kept at school. Students are <u>NOT</u> allowed to transport medicines. Medical forms may be obtained from the office, and are renewed each year for each medication.

PLEASE READ THE EMERGENCY ACTION PLAN FOR ASTHMA ON THE REVERSE SIDE, AND ADD ANY ADDITIONAL INFORMATION.