



ASTHMA Emergency Action Plan

Keller ISD Health Services Department

Name: _____ DOB: _____ Teacher/Grade: _____

Emergency Contact #1: _____	Preferred Contact Number: _____
Emergency Contact #2: _____	Preferred Contact Number: _____
Physician for Asthma: _____	Phone Number: _____
Preferred Hospital: _____	

CHECK IF APPLICABLE

Signs and Symptoms	Triggers	What helps your child during an asthma attack?
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Exercise <input type="checkbox"/> Makers	<input type="checkbox"/> Loosen Clothing
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Cold Air <input type="checkbox"/> Perfume	<input type="checkbox"/> Administer Medication
<input type="checkbox"/> Chest Tightness	<input type="checkbox"/> Dust <input type="checkbox"/> Smoke	<input type="checkbox"/> Rest/Relaxation
<input type="checkbox"/> Cough	<input type="checkbox"/> Stress <input type="checkbox"/> Animals	<input type="checkbox"/> Breathing Exercise
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
_____	_____	_____
_____	_____	_____

Will student require peak flow monitoring? Yes No If yes, answer below:

What is the personal best peak flow number? _____

Times peak flow should be checked during school: _____

Please list medications to be administered at school for asthma: *(Medication Authorization form required)*

Will student need a nebulizer at school? Yes No

Will student carry an inhaler during the school day? Yes No *If yes, a separate form must be completed by parent/physician. *An extra inhaler should be kept in school clinic.*

STEPS TO TAKE DURING AN ASTHMATIC EPISODE:

1. Administer authorized medication as directed
2. Monitor student

3. SEEK EMERGENCY MEDICAL CARE IF STUDENT EXPERIENCES ANY OF THE FOLLOWING:

- No improvement after initial treatment with medication and a relative cannot be reached.
- Student exhibits any of the following:
 - *Chest and neck pulled in when breathing. Hunched over while breathing. Struggling to breath. Trouble walking or talking. Lips or fingernails turn cyanotic.*

Parent Signature: _____ Date: _____

Registered Nurse Signature: _____ Date: _____

Licensed Vocational Nurse Signature: _____ Date: _____

Asthma EAP electronically sent via Laserfiche to all staff directly involved with student services. Date: _____