Plan effective for school year:

ASTHMA—Emergency Care Plan

Student Name: ID#: Grade: DOB:

Student Photo

Parent/Guardian: Home: Work:

Cell:

Home: Work:

Cell:

Emergency Contact: Phone:

Physician: Phone:

Current Medication: *****MED MUST GO ON FIELD TRIPS*****

Allergies:

SIGNS of ASTHMA ATTACK

MILD	MODERATE	SEVERE (EMERGENCY)
▪ Cough ▪ Difficulty Breathing ▪ Other:_____ _____ _____ _____ _____ _____ _____ _____	▪ May have mild symptoms, too ▪ Complaints of chest tightness ▪ Difficulty breathing ▪ Unusual sounds with breathing (Wheezing) ▪ Anxiety (student looks scared) ▪ Nostril flaring ▪ Shoulders hunched over ▪ Other:_____ _____	▪ **May have moderate symptoms, too** ▪ **Lips, nails, or mouth are pale, gray, or bluish colored** ▪ **Heart racing (pulse over 120)** ▪ **Gasping breaths** ▪ **Chest & neck "pulling in"** ▪ **Severe restlessness** ▪ **Unable to speak in complete sentences without taking a breath** ▪ **Decreasing or loss of consciousness**

IF YOU SEE THIS	DO THIS **Never send student anywhere alone!!!**	TIME/ Initials
MILD OR MODERATE SYMPTOMS	▪ Medication is Located:_____ ▪ If unable to go to health office, notify School Nurse & have meds brought to student if necessary. ▪ Sit student upright position & offer water. ▪ Instruct to breathe in through nose & out through pursed lips slowly and deeply. *Check time of last dose of medication.* ▪ **Trained personnel to give_____by inhaler or nebulizer____ hours apart. Assist student to inhale medication slowly and fully. *Follow Student's Plan.***	
NO IMPROVEMENT WITHIN 15 MINUTES after medication **or** **SEVERE SYMPTOMS**	Call Parents **Call 911** *Adult trained in CPR/Rescue Breathing stays with student*	
BREATHING STOPS	**Begin CPR/Rescue Breathing**	

Complete med log. Note time of arrival and departure of ambulance; send a copy of form with the ambulance.

A copy of this plan will be kept in the school office and copies will be given to bus and PE/athletic department staff. Teachers will be notified that student has a plan on file in the office Signature by parent indicates agreement with this plan.

RN Signature Date

Parent Signature Date

CONFIDENTIAL