



**NAME:** \_\_\_\_\_  
**DOB:** \_\_\_\_\_ **Gender:** M F **Grade:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_  
**Home Room Teacher:** \_\_\_\_\_ **Primary Language:** \_\_\_\_\_

**ASTHMA EMERGENCY CARE PLAN**

Person to Contact	Relationship	Primary Phone	Secondary Phone
1.			
2.			
3.			

Health Care Provider Treating Student for Asthma: \_\_\_\_\_ Phone: \_\_\_\_\_

**CIRCLE** factors that may cause an asthma episode: cold weather, cigarette smoke, dust mites, exercise, respiratory infection, strong odor, pollens, mold, foods and/or OTHER: \_\_\_\_\_

**IF YOU SEE/HEAR THIS**

- |   |  |
|---|--|
| <ul style="list-style-type: none"> <li>● Difficulty breathing</li> <li>● Wheezing</li> <li>● Shortness of Breath</li> </ul> | <ul style="list-style-type: none"> <li>● Coughing</li> <li>● Chest tightness</li> <li>● Symptoms with play, exercise, or other daily activities</li> </ul> |
|---|--|

**DO THIS**

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>● Stay with student, speak softly, and stay calm</li> <li>● Keep person sitting upright and encourage slow deep breathing – in through the nose and out through puckered lips</li> <li>● Give sips of water</li> <li>● Give quick-relief medication as ordered</li> </ul> | <p>Name and Location of medication: _____</p> <ul style="list-style-type: none"> <li>● Other: _____</li> </ul> |
|--|--|

**CALL 911 IF:**

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>● No relief from medication</li> <li>● Continuous spasmodic coughing</li> <li>● Trouble walking or talking</li> <li>● Lips or fingernails turning (darkening) grey or blue</li> <li>● Increased anxiety or confusion</li> </ul> | <ul style="list-style-type: none"> <li>● Grunting respirations</li> <li>● Restlessness</li> <li>● Exhaustion</li> <li>● Neck muscles tighten</li> </ul> |
|--|---|

**\* Administer CPR if breathing stops! Continue until paramedics arrive! \***

Current medications: \_\_\_\_\_

- My child, \_\_\_\_\_, has my permission and a physician's order to carry his/her inhaler during the school day.
- I want this plan implemented for my child, \_\_\_\_\_, in school. I give my permission for exchange of confidential information contained in the record of my child between the nurse and physician. My signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the school nurse.

Health Care Provider Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 LSN Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Plan Reviewed – LSN Initials: \_\_\_\_\_ Parent Initials: \_\_\_\_\_ Date: \_\_\_\_\_  
 Plan Reviewed – LSN Initials: \_\_\_\_\_ Parent Initials: \_\_\_\_\_ Date: \_\_\_\_\_

**RETURN THIS FORM TO THE HEALTH ROOM**