For Office Use Only: Grade/Teacher: _____
Location of medication:
Health Room Student Bus Other_____

ASTHMA Emergency Action Plan – Kershaw County School District

Student: _____ DOB:_____

Emergency Contact Name: _____Relationship: _____

Home: _____ Work: _____Cell: _____

Preferred Emergency Facility or Hospital: _____

Other Medical Diagnoses:_____

ALLERGIES: _____

How long has your child had asthma?_____ **Has child been hospitalized for asthma**?_____

Dates of hospitalizations:_____

Triggers: • Weather (cold air, wind) • Illness • Exercise • Smoke • Dog/Cat • Dust • Mold • Pollen •Other: _____

Does your child recognize signs and symptoms of asthma? • No • Yes

Describe what happens when your child is experiencing asthma symptoms: _____

*Please list **all** medications taken by your child. (daily and/or as needed)*

MEDICATIONS	

Does your child have any restrictions relating to activities at school or school sponsored functions? (PE, athletics, etc.)
□ NO □ YES (note from physician required):_____

PRETREATMENT STEPS FOR EXERCISE: (Health Provider, please complete section by checking appropriate interventions)

• Give _____ puffs quick relief med (name):_____ 15 minutes before activity.

(Circle indication: PE class, exercise/sports, recess) Explanation: _____

• Repeat in 4 hours if needed for additional or ongoing physical activity.

TREATMENT FOR SIGNS/SYMPTOMS: (Health Provider please complete dosing for quick relief med)

IF YOU SEE THIS:

- Difficulty breathing
- Wheezing
- Frequent Cough
- Complaints of chest tightness
- Unable to tolerate regular activities but still talking in complete sentences
- Other:_____

DO THIS:

- Stop physical activity
- Give _____ puffs quick relief med(name):_____
  • via spacer • with mask • other: _____
- If no improvement is seen in 10–15 minutes, repeat the use of rescue medication.
- If student's symptoms do not improve or worsen, call 911
- Stay with student and maintain sitting position
- Call parent/ guardian and school nurse
- Student may resume normal activities once feeling better.

IF THERE IS NO QUICK RELIEF INHALER AT SCHOOL:

- CALL Parent/Guardian to pick up student and/or bring inhaler/medications to school.
- Inform them that if they are unable to attend school, 911 may be called.
- Notify School Nurse and/or Administrator.
- Stay with the student.

OVER

ASTHMA Emergency Action Plan – Kershaw County School District

Student: _____ **DOB:**_____

IF YOU SEE THIS:	**DO THIS:**
▪ Coughs constantly ▪ Struggles or gasps for breath ▪ Trouble talking (can speak only 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ Decreased level of consciousness	• Give _____ puffs quick relief med(name):_____ • via spacer • with mask • other: _____ • If no improvement in 10 – 15 minutes, repeat use of rescue med: ▪ Refer to anaphylaxis plan if student has life life-threatening allergy. ▪ Call 911. Inform dispatch the student has asthma. ▪ Call parent/guardian and school nurse. ▪ Encourage student to take slow, deep breaths. ▪ Stay with student and remain calm. ▪ *School personnel should not drive student to hospital.*

IF THERE IS NO QUICK RELIEF INHALER AT SCHOOL:

- CALL 911. Inform dispatch the student has asthma.
- CALL Parent/Guardian and School Nurse.
- Notify Administrator.

APPROVALS:

_____ _____ _____

HEALTH CARE PROVIDER SIGNATURE | PLEASE PRINT PROVIDER'S NAME | DATE

_____ _____

SCHOOL NURSE SIGNATURE | DATE

By signing this document, the parent/guardian and/or the student authorize sharing this information with school personnel who have a legitimate need for knowledge of the information.

_____ _____

PARENT SIGNATURE | DATE

Copies of this plan provided to: • Teachers • Phys Ed/Coach • Principal • Main Office • Bus Driver • SEAGUL • Other:_____

DATE	***NOTES***

OVER