RYE CITY SCHOOL DISTRICT
Health Care Services
Rye, NY 10580

Place Child's Picture Here

ASTHMA
EMERGENCY HEALTH CARE PLAN

Name of Student: _____ **D.O.B:** ____/____/____ **Grade:** _____

SYMPTOMS:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath, and respirations greater than 22/minute
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, difficulty in walking/talking
- **APPEARS:** anxious, sweating, nauseous, fatigued, gasping for air, the use of neck muscles when breathing
- **RAPID PULSE:** greater than 120/minute
- Other:_____
- If reaction is progressing (several of the above areas affected) give

REQUIRED ACTION: ▫ *Stop all activity immediately* ▫ *Help student assume a comfortable position* ▫ *Notify school nurse*

TREATMENT (Physician Must Complete) ***TO BE DATED ON/AFTER JULY 1ST FOR UPCOMING SCHOOL YEAR***

Medication & Dosage: _____

Inhaler Order (PRN): _____/_____/_____
Route Frequency Indication

Authorization for Self-Directed (Inhaler Only): YES □ NO □ (*please check*)

He/she is self-directed, has been instructed in the procedure of self-administration and can assume responsibility for carrying his/her own properly labeled medication in the original container. He/she understands the purpose, the correct dose, the possible side effects, and the frequency of use. I request that he/she be permitted to carry his/her own medication, including Field Trips, or to keep own medication in his/her locker. The School Nurse has final approval.

Doctor's Signature: _____**Date:** _____
(Required)
STAMP/LICENSE/ADDRESS: _____**Phone:** _____
(Required)

EMERGENCY ACTION:

1. **Give medication as prescribed under Treatment.**
2. **CALL AMBULANCE: 911 (Police: (914) 967-1234). Worsening symptoms after initial treatment.**
3. **CALL PARENT/GUARDIAN:** _____

I request that my child receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I give permission for my child to receive the prescribed medication as directed and under the supervision of the school nurse or designated other.

Parent/Guardian Signature: _____ **Date:** _____