

Date Plan Was Developed: _____

Call School Nurse! _____

Phone _____

ASTHMA - EMERGENCY CARE PLAN

Is this condition potentially Life Threatening ? Yes ___ No ___
 Never send student with any asthma symptoms anywhere alone !!!

Student Name: _____

DOB: _____

Student Picture _____

Parent/Guardian: _____

Home Phone: _____

Work Phone: _____

Emergency Contact: _____

Home Phone: _____

Work Phone: _____

Physician: _____

Phone: _____

Teacher: _____

Allergies: _____

Current Medication: _____

Triggers: _____

SYMPTOMS of an ASTHMA ATTACK

MILD	MODERATE	SEVERE
Cough Difficulty Breathing	Chest tightness Difficulty Breathing Unusual sounds with breathing (Wheezing) Anxious (look scared) Nostrils flaring Shoulders hunched over	Lips, nails, or mucous membranes are pale, gray, or bluish Rapid pulse (over 120 per minute) Gaspings breaths (over 30 per minute) Chest and neck "pulling in" with breathing Severe restlessness Unable to speak in complete sentences without taking a breath Decreasing or loss of consciousness
*Student's usual signs/symptoms	*Student's usual signs/symptoms	*Student's usual signs/symptoms

IF YOU SEE THIS	DO THIS Never send student anywhere alone!!!!	TIME Initial
MILD or MODERATE SIGNS	Medication Located: _____ If unable to go to health office, have meds brought to student if necessary Sit student in upright position, if conscious offer water. Instruct to breathe in through nose and out through pursed lips slowly and deeply. Check time of last dose of medication. *Give _____ by inhaler or nebulizer _____ hours apart Assist student to inhale medication slowly and fully.	
NO IMPROVEMENT WITHIN 15 MINUTES after medication	Notify parents. If possible, adult trained in CPR/Rescue Breathing stays with student.	
SEVERE SYMPTOMS	Call 911	
BREATHING STOPS	Begin CPR	
Note time of arrival and departure of ambulance; complete this form, initial, and send a copy of form with the ambulance.		

Registered Nurse's Signature _____

Date _____

Principal's Signature _____

Date _____

Parent/Guardian Signature _____

Date _____

Primary Health Care Provider's Signature _____

Date _____

The following **staff members** have been given a copy of this Emergency Care Plan: Parent Physician Principal
 Teacher(s) Resource PE Music Library Transportation Recess Office Other