Asthma Emergency Care Plan

Student's Legal Name: _____

Grade: _____ DOB: _____School Year: _____

Mother: _____ Phone: _____

Father: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Student Photo

Asthma Information

Your child's age of onset of asthma symptoms: _____ **Age of diagnosis:** _____

Medical alert jewelry worn: ☐Yes ☐No **IEP:** ☐Yes ☐No **504 Plan**: ☐Yes ☐No

SYMPTOMS that display an asthma episode (check all that apply):

☐ Wheezing ☐ Coughing ☐ Shortness of breath ☐ Chest tightness

☐ Other Specify _____

Asthma Medicine *(To be Completed by a Recognized Medical Authority*)*

Can student carry and self-administer? ☐Yes ☐No

Name of Medication	Dosage Prescribed	Administration Time/Frequency

** Physician, Physician Assistant, or Nurse Practitioner licensed to practice in the State of California*

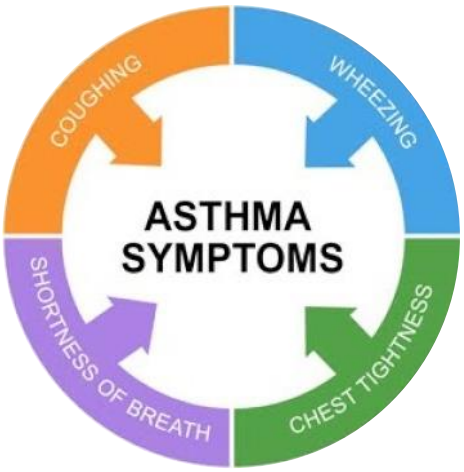
Date: _____

Print Physician's Name: _____

Office Stamp

Physician's Signature: _____

Parent/Guardian Signature: _____ Date: _____



Student Statement for Self-administration

I understand that, I am able to carry and self-administer ONLY the medication listed above at school. I agree to use the inhaler as instructed by my physician and not to share it with other people. I also, understand that if I share the medication with others, I will be held accountable and will face disciplinary consequences for my action.

Student's Signature: _____

Date: _____

This plan is in effect for only one school year.

Asthma Emergency Care Plan

All Emergency Care Plans need to be updated annually. The information given assists the district nurse in developing an Individual Healthcare Plan for each student.

1. **DURING THE DAY**, how often does your child have a hard time with coughing, wheezing, or breathing?
   ☐ 1-2 times a week ☐ 3 or more times a week ☐ All the time, throughout the day, every day

2. **AT NIGHT**, how often does your child wake up or have a hard time with coughing, wheezing, or breathing?
   ☐ **Monthly:** ☐ 2 nights or less a month ☐ More than 2 nights a month
   ☐ **Weekly**: ☐ More than 2 nights a week ☐ More than 4 nights a week

3. **How much does asthma bother or interrupt your child's normal activities** (playing, sports, running around)?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ All of the time

4. **How many times has your child been to the emergency room or hospitalized for asthma in the past year?**
   ☐ None ☐ Once ☐ Twice ☐ 3 times ☐ 4 times ☐ 5 or more times

5. **How many days did your child miss school last year for asthma symptoms** (wheezing, coughing, shortness of breath?)
   ☐ None ☐ 1-2 days ☐ 3-5 days ☐ 6-9 days ☐ 10-14 days ☐ 15 or more days

6. **Does your child also have a life-threatening allergy or anaphylaxis?** ☐Yes ☐No

7. **Does your child have an Asthma Action Plan (AAP), written by a healthcare provider?** ☐Yes ☐No
   If yes, has a copy been given to the school? ☐Yes ☐No

8. **Special considerations and precautions** (check all that apply and describe any actions that should be taken):
   ☐ General health _____
   ☐ P.E. & sports _____
   ☐ Learning _____
   ☐ Recess _____

Signs of an asthma emergency:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking
- Blue-gray discoloration of lips and/or fingernails
- Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment
- Pulse greater than 120/minute
- Respirations greater than 30/minute

Treatment:

- Stop activity immediately
- Help student assume a comfortable position. Sitting up is usually more comfortable
- Encourage purse-lipped breathing
- Encourage fluids to decrease thickness of lung secretions
- Observe for relief of symptoms. If no relief noted in 15-20 minutes call 911