



Student's Legal Name: \_\_\_\_\_

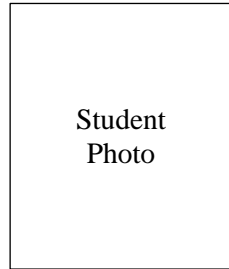
Grade: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: \_\_\_\_\_

Mother: \_\_\_\_\_ Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_



### 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