

EMERGENCY CARE PLAN (ASTHMA)

Student Name: _____ D.O.B: _____ Grade: _____ Room: _____

Address: _____ Home Phone #: _____

Mother's Name: _____ Work Phone #: _____ Mobile: _____

Father's Name: _____ Work Phone #: _____ Mobile: _____

Doctor's Name: _____ Doctor's Phone #: _____

Hospital: _____ Insurance: _____ Policy #: _____

EARLY SIGNS OF AN ASTHMA EPISODE:

1. Change in breathing may include:

- Coughing
- Wheezing
- Breathing through the mouth
- Shortness of breath, and/or rapid breathing

2. Verbal Complaints. Often a student who is familiar with asthma will know that an episode is about to happen.

The student might tell the teacher that:

- Chest is tight
- Chest hurts
- He/she cannot catch a breath
- Mouth is dry
- Neck feels funny
- A more general "I don't feel well."

3. Other signs may be:

- An itchy chin or neck – some people may rub their chin or neck in response to this feeling, or
- "clipped" speech – the student may speak in very short, choppy sentences.

ACTION FOR TEACHER TO TAKE:

- Give medication(s):

(If in classroom or on student)

- If the student is able, have him/her go to the office. Have someone accompany student to the office.
- Call the office
 - to let them know the student is coming OR
 - you need the medication brought to your room and you need assistance.

If there is no improvement after 5 - 10 minutes and a relative cannot be reached, it may be an asthma emergency.

ASTHMA EMERGENCY ACTION:

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking or talking. Chest and neck pulls in with breathing.
- Blue or gray discoloration of the lips or fingernails.
- Child is hunched over and struggling to breathe.
- Failure of medication to reduce worsening symptoms or no improvement 15-20 min. after initial treatment.

These signs indicate the need for emergency medical care. The steps that should be taken are:

1. CALL 911 (from the classroom dial 8-911).
2. Reassure Student, stay calm and stay with the student.

I GIVE MY CONSENT FOR THIS INFORMATION TO BE SHARED WITH SCHOOL STAFF

Parent's Signature: _____ Date: _____

School Nurse's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____

Teacher's Signature: _____ Date: _____

ASTHMA INFORMATION FOR SCHOOL

Student Name: _____ D.O.B: _____ Grade: _____ Room: _____

• **Identify the things which start an asthma episode** (check each that applies to your child)

- | | | |
|------------------------------|-----------------------------|---------------------------|
| _____ Exercise | _____ Strong odors or fumes | _____ Pollen |
| _____ Respiratory Infections | _____ Chalk dust | _____ Carpets in the room |
| _____ Change in temperature | _____ Animals | _____ Food: |
| _____ Molds | _____ Other: _____ | |

• **Does your child have any physical limitations*?**

Yes (if yes, please list.) No

Limitations: _____

• **Does exercise induce episodes of asthma?**

Yes (if yes, please list.) No

Exercises that induce asthma? _____

• **Do certain weather conditions affect your child's asthma?**

Yes (if yes, please list.) No

Weather: _____

• **Name(s) of medication* taken, dose, how often, and under what circumstances additional doses should be given.**

Name: _____

Name: _____

Dose: _____

Dose: _____

How often? _____

How often? _____

Additional dose? _____

Additional dose? _____

• **Any side effects to the above medications?**

Yes (if yes, please list) No

Side Effects: _____

• **Does your child understand asthma and what he should do to manage it?**

Yes No

• **Approximately how often does your child have an acute asthma episode?**

• **How do you want the school to treat an episode of asthma if it should occur at school?**

• **COMMENTS:**

***If your child needs any medication at school a Medication Consent Form must be completed by both the doctor and parent. In order to comply with any physical limitations, a note from the doctor specifying the limitations is required.**

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Parent's Signature: _____ Date: _____