_____'s Asthma Emergency Action Plan

Student's Name

☐ Bus Rider: #_____
☐ Car Rider

Student's Date of Birth:_____

School:_____ Teacher:_____ Grade:_____

1) Parent/Guardian:_____ Phone: (w)_____ (c)_____ (h) _____

2) Parent/Guardian:_____ Phone: (w)_____ (c)_____ (h)_____

3) Emergency contact:_____ Phone: (w)_____ (c)_____ (h)_____

Physician:_____ Phone:_____ Fax:_____

Asthma Episode Protocol

Date of Last Asthma Attack: _____

Student has been diagnosed with: (other medical conditions)_____

_____

Emergency action is necessary when the student has symptoms such as: _____

_____

Asthma Episode Protocol

1. Give medication as listed below: (Student should improvement in 15-20 minutes)
2. Contact Parent/Guardian: _____

Asthma Triggers

- ☐ Exercise
- ☐ Strong odors or fumes
- ☐ Respiratory Infections
- ☐ Chalk/Dust
- ☐ Change in temperature
- ☐ Carpets in Rooms
- ☐ Animals
- ☐ Pollens
- ☐ Foods : _____
- ☐ Molds
- ☐ Other: _____

Asthma Emergency

Seek Emergency Medical Treatment if student displays any of the following:

- Coughs Constantly
- Hard time breathing with:
  - Chest and neck pulled in with breathing
  - Stooped body Posture
  - Struggling or gasping
- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Trouble walking or talking
- Stops playing and can't start activity again
- Lips or fingernails are grey or blue

Treatment Protocol During School Hours *(Including Daily Medications and Emergency Medications)*

* If Emergency.	Medication	Dosage & Time to be given	Common Side Effect & Special Instructions
☐			
☐			

Special Considerations and Precautions (Regarding school activities, trips, sports, etc.)

Parent Signature Required	_____ Parent Signature	_____ Date
Nurse Signature Reviewed	_____ Nurse Signature	_____ Date