



Emergency Care Plan



ASTHMA

Student: _____ Grade: ____ DOB: _____ Asthma Triggers: _____
 Parent #1: _____ Home #: _____ Work #: _____ Cell #: _____
 Parent #2: _____ Home #: _____ Work #: _____ Cell #: _____
 Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, “neck feels funny,” doesn’t feel well, speaks quietly.
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

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.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

TREATMENT:

Stop activity immediately.
 Help student assume a comfortable position. Sitting up is usually more comfortable.
 Encourage purse-lipped breathing and encourage fluids to decrease thickness of lung secretions.
 Give medication as ordered:

Name of Medication _____

Dosage Schedule _____

Possible side effects _____

*self-carry Yes ___ No ___

Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.
 Notify school nurse who will call parents/guardian and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

- Call 911 (Emergency Medical Services) and inform them that you have an asthma emergency. .
- A staff member should accompany the student to the emergency room if the parent, guardian, or emergency contact is not present and adequate supervision for other students is present. Preferred Hospital if transported: _____

*I attest that this student has demonstrated to me that they can self-administer this medication.

Physician’s Signature _____ Date: _____

Physician’s Name (please print) _____ Phone: _____

Parent/Guardian Signature: _____ Date: _____

** This plan will be shared with pertinent staff on an as need to know basis.

This plan is in effect for the current school year and summer school as needed.