EMERGENCY PLAN – ASTHMA

Student Name _____Teacher/Grade_____
Parent/Guardian Name:_____
Address:_____
Phone (home): _____(work):_____
Parent/Guardian Name:_____
Address: _____
Phone (home): _____(work):_____
Other Contact Information:_____
Emergency Phone Contact #1-Name:_____
Relationship: _____Phone:_____
Emergency Phone Contact #2-Name:_____
Relationship: _____Phone:_____
Physician Child Sees for Asthma:_____
Phone:_____

❖ **Daily Medication Plan for Asthma**

Name	Amount	When to Use

OUTSIDE ACTIVITY AND FIELD TRIPS The following medication must accompany student when participating in outside activities and field trips.

Name	Amount	When to Use

DAILY ASTHMA MANAGENMENT PLAN

❖ **Identify the things that start an asthma episode**
(Check each that applies to the student)

_____animals _____bees/insect sting _____chalk dust _____latex
_____dust mites _____exercise _____molds _____pollens
_____smoke _____strong odors _____change in temperature
_____respiratory infections
_____food: _____
_____other: _____

Peak Flow Monitoring (for students over 4 years old)

Personal Best Peak Flow Reading: _____

Monitoring Times: _____ _____ _____

Control of Environment (List any environmental control measures, premedications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

_____

_____

ASTHMA EMERGENCY PLAN

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

_____

or has a peak flow reading at or below _____

❖ **Steps to take during an asthma episode:**

1. Check peak flow reading (if student uses peak flow meter).
2. Give medications as listed below.
3. Check for decreased symptoms and/or increased peak flow reading.
4. Allow student to stay in school if: _____

   _____
5. Contact Parent/Guardian.
6. Seek emergency medical care if the student has any one of the following:
   - No improvement _____minutes after initial treatment with medication.
   - Peak flow at or below _____
   - Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Student hunched over.
     - Student struggling to breathe.
   - Trouble walking or talking.
   - Stops playing and cannot start activity again.
   - Lips or fingernails are gray or blue.

****IF ABOVE HAPPENS, GET EMERGENCY HELP NOW! ****

- **Emergency Asthma Medications:**

Name	Amount	When to Use

- **Special Instructions:**

_____

_____

_____

Physician Signature Date

_____

Parent/Guardian Signature Date

_____

School Nurse Signature Date