Emergency Care Plan

ASTHMA

Student: _____ Grade: ____ DOB: _____ Asthma Triggers: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

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. & 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 the 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.

Revised 1/08