EMERGENCY ACTION PLAN

Asthma

Student's Name_____DOB_____Grade/Teacher_____Bus____

Emergency contacts: _____ Ph:_____

Emergency contacts: _____ Ph:_____

Allergies: _____

****EMERGENCY PLAN:****

Emergency Action is necessary when the student has symptoms such as:

Coughing	Tight chest	Difficulty breathing
Wheezing	Nose opens wide	Difficulty talking

1. **Attempt to calm student. Stay with student.**
2. **Have student take prescribed medication as ordered by health care provider signed by parent ("Physician's Authorization for Medication" form).**
3. **Have student sit in a resting position, breathing slowly through the mouth, exhaling slowly through pursed lips.**
4. **Offer fluids.**
5. **Notify school nurse if in the building.**
6. **Notify parent for severe breathing difficulty or if medication is not effective after 15 minutes.**
7. **If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to closest hospital.**

Parents are responsible for providing back-up medications to the school in a location that the student has immediate access to if needed for an asthma or anaphylaxis emergency.
Back-up medication will be located _____.

If a student uses asthma medication prescribed in a manner other than as prescribed, a school may impose on the student disciplinary action according to the school's disciplinary policy. A school may not impose disciplinary action that limits or restricts the student's immediate access to the asthma medication

Asthma medication may be used on school property during the school day, at school-sponsored activities, or while in transit to or from school-sponsored events.

By signing below, the school nurse has your permission to share this Emergency Action Plan with appropriate school personnel.

PARENT/GUARDIAN
SIGNATURE _____ DATE _____

PLEASE NOTE: All inhalers/nebulizers MUST be registered with the school nurse. Exp date: _____

☐ Student has demonstrated ability to the school nurse to use the asthma medication and any device that is necessary to administer the medication appropriately.

*BCS and its employees/agents are not liable for an injury arising from a student's possession and self-administration of asthma medication.

SCHOOL NURSE _____ DATE _____

****If your child requires medicine at school, a doctor must complete a "Physician's Authorization for Medication" form.****

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EMERGENCY ACTION PLAN ASTHMA

STUDENT NAME_____ SCHOOL: _____

TEACHER/GRADE _____ YEAR: _____

PARENT/GUARDIAN _____ PHONE _____

HEALTH CARE PROVIDER _____ PHONE _____

1. Briefly describe what causes the child's asthma symptoms (weather, cold, allergies, exercise):
   _____
2. How often does the child have an asthma attack so severe that he/she needs to see a health care provider or go to the hospital? _____
3. Name any medication that the child takes for his/her asthma (how often and how much):
   At home _____
   At school _____
4. Does your child suffer any side effects from these medications? Please list them:
   _____
5. Name any activities/ exercises in which your child CANNOT participate:
   _____
6. What does your child do at home to relieve wheezing during an asthma attack?

   __ Breathing exercises

   __ Rest/ Relaxation

   __ Drinks liquids

   Takes medicine: __ Inhaler

   __ Nebulizer

   __ Oral Medicine

7. Do you know what your child's baseline peak flow rate is?
   __ Yes __ No What is it? _____
8. How do you want the school to treat as asthma attack if it should happen?
   _____

PLEASE ADD ANY FURTHER INSTRUCTIONS: