Sacred Heart School

# *Emergency Health Care Plan: Asthma*

STUDENT: _____ GRADE: _____

PARENT/GUARDIAN: _____ PHONE: _____

PARENT/GUARDIAN: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

PHYSICIAN: _____ PHONE: _____

**WHAT TRIGGERS ASTHAMA EPISODE:**

☐ Exercise ☐ Colds ☐ Weather change ☐ Cold Air ☐ Emotions

☐ Irritants ☐ Molds ☐ Animal Dander ☐ Cigarette Smoke ☐ Odors

☐ Pollens ☐ Dust ☐ Other: _____

**SYMPTOMS OF RESPIRATORY DIFFICULTY: (ANY OR ALL OF THE FOLLOWING)**

☐ Coughing ☐ Blue fingernails/lips/skin ☐ Shortness of breath

☐ Chest tightness ☐ Rapid, labored breathing ☐ Difficulty conversing

☐ Difficulty walking ☐ Decreasing or loss of conciousness ☐ Other: _____

**ACTION**

Peak flow meter: ☐ YES ☐ NO

Spacer: ☐ YES ☐ NO

☐ Have student stop whatever he/she is doing at onset of symptoms.

☐ Send student to Nurse's Office with another person. Notify nurse of student's arrival.

**TREATMENT**

INHALER: (Name of medication and directions for use):_____

NEBULIZER: Name of medication and directions for use): _____

OTHER: (Name of medication and directions for use): _____

LOCATION OF MEDICATION:_____

Can student self medicate (Requires permission from physician in writing)? ☐ YES ☐ NO

Does student have permission to carry inhaler on person? ☐ YES ☐ NO

*Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require reassessment of the permission to self medicate.*

**FIELD TRIPS**

Medication (_____Yes _____No) and peak flow meter( _____Yes _____No) MUST accompany student on all field trips. A copy of this Health Care Plan and current phone numbers MUST be with staff member, teacher or designee MUST be instructed on correct use of asthma medications. I give my permission for the information to be shared with adults at NASD on a need to know basis. This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the Health Service office whenever there is a change in my child's health status or care.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

_____ _____

PHYSICIAN SIGNATURE DATE

_____ _____

SCHOOL NURSE SIGNATURE DATE