ST. MARY'S SCHOOL

ASTHMA EMERGENCY CARE PLAN

Student's name:_____Grade/Teacher's name:_____

Known Allergies_____

Parent/Guardian/Emergency Contacts:

Call 1st: _____Cell:_____Other Daytime:_____

Call 2nd: _____Cell:_____Other Daytime:_____

Call 3rd: _____Cell:_____Other Daytime:_____

Check all that apply regarding your child's asthma history:

Signs and Symptoms:	Triggers:	Actions to Take:
❏ Wheezing	❏ Exercise	❏ Administer rescue inhaler
❏ Difficulty breathing	❏ Cold air	❏ Loosen clothing
❏ Chest tightness	❏ Stress	❏ Rest/relaxation
❏ Cough	❏ Colds/illness	❏ Breathing exercises
❏ Restless/anxious	❏ Smells (markers etc.)	❏ Sip room temp water
❏ Difficulty talking	❏ Allergies_____	❏ Elevate arms
❏ Other_____	❏ Other_____	❏ Other_____

Will student potentially require a nebulizer treatment at school? Yes_____ No_____

***If yes**, nebulizer tubing, chamber, and mask must be provided. A nebulizer machine is available for student use at each school.

Will student self-carry an inhaler during the day? Yes_____ No_____

***If yes**, an extra inhaler should also be kept in the school health office. Please see reverse.

Steps to Take During an Asthma Episode - Emergency Protocol

1. Remain calm. Reassure the student and do not leave them alone.
2. Accompany student to health office.
3. Administer authorized rescue medication as directed and perform any other recommended actions as listed above.
4. **Call 911 if student experiences any of the following:**
   - ★ No improvement 15-20 minutes after using medication OR if no medication is available.
   - ★ If breathing symptoms worsen (lips blue, trouble talking, confusion, increased anxiety)
5. Alert Parent/Guardian(s).

Physician's Authorization for Medication Administration

Emergency Medication	Dosage	Time	Special Instructions

Physician's Printed Name:_____Phone: _____

Physician's Signature X_____Date:_____

Please see reverse side of this form for Parent Authorization and Self Administration Procedure

OVER→

Asthma Emergency Care Plan Continued:

Authorization For Staff Administration Of Medication Including When on Field Trips

I understand that trained school personnel will follow the Asthma Emergency Care Plan as completed by my child's physician, school nurse, and myself. Further, under the delegation of the LSN/RN, I hereby give my permission that trained school personnel can administer my child's rescue inhaler in the absence of a school nurse and if my child is away from the school on a field trip or other school activity. I release school personnel from any liability in relation to this request when the medication is given as ordered.

Parent/Guardian Signature_____Date:_____

Authorization to Share Health Information with St. Mary's SAC Program

❏ Not applicable

My child will be attending SAC on various days throughout the school year. I authorize that a copy of my child's Asthma Emergency Health Plan and physician prescribed Asthma Action Plan (when applicable) may be shared with the SAC program supervisor(s) for collaboration and continuity of care during before and after school hours.
PLEASE NOTE: PARENT MUST PROVIDE ADDITIONAL RESCUE INHALER TO THE SAC SUPERVISOR.

Parent/Guardian Signature_____Date:_____

Self-Administration Of Medication

❏ Not applicable

I hereby authorize my child to self-administer the above named medication(s) during school as prescribed by the physician. I have read the student agreement. I understand that my child will carry this medication at school and use will not be monitored by school personnel. I understand that trained school personnel will follow the Asthma Emergency Care Plan as completed by my child's physician, school nurse, and myself should my child be unable to self-administer his/her medication.

Parent/Guardian Signature:_____Date:_____

Student Agreement for Self-Administration of Medication (Certain age??)

❏ Not applicable

I agree to:

- Follow my prescribing physician medication orders.
- Use correct medication administration technique.
- Not allow anyone else to use my medication.
- Keep a supply of my medication with me in school and on field trips.
- Notify the school nurse or health office personnel if I am experiencing asthma symptoms that are not relieved by 2 initial puffs of my inhaler, or am having difficulty breathing at any point.

Student Signature:_____Date:_____
**The student has demonstrated knowledge about proper use of his/her medication (rescue inhaler).

LSN/RN Signature:_____Date:_____

This Asthma Emergency Care Plan has been reviewed.

LSN/RN Signature:_____Date:_____