NORTH BRANCH AREA PUBLIC SCHOOLS
Inspire Dreams, Build Integrity, Instill Hope

Teacher:_____

Asthma Emergency Health Care Plan

Name:_____Date of Birth:_____ Grade:_____ School Year:_____
Parent/Guardian(s):_____
Phone-Cell:_____ Work:_____
Medications:_____
Allergies:_____
Additional Medical Diagnosis:_____
Emergency Hospital:_____
****

PLAN:

- ❑ *Signs/Symptoms: (Circle all that may apply)*
  Wheezing, coughing, shortness of breath, paleness, flushed around cheeks and ears, bluish color to lips/fingernail beds, restlessness, retractions in chest/rib area, and/or anxiety

- ❑ ***Is Able***
- ❑ ***Not Able*** *to tell when having increased difficulty breathing*

- Do not leave student alone. Adult will escort to the health office
- Health office will monitor peak flow ranges (if ordered); prior to treatments and 10 minutes after treatments
- Trained staff will assist with medications as prescribed/authorized by physician and provided by parent
- **If breathing hasn't improved or if staff is concerned call nurse and/or 911**
- Encourage slow deep breaths, keep comfortable in an upright position
- Health office staff will notify parent if needed for additional information and/or concerns

If student has difficulty on the bus, and does not have their inhaler with them OR if the inhaler medication is ineffective:

-Pull the bus to the side of the road
-Radio bus garage and/or call 911
-Stay with the student and keep calm

_____**Carries Inhaler with him/her** _____**Inhaler in health office** _____**No inhaler in parent**
(Parent Responsibility)

1. How long has your child had asthma? _____

2. Please rate the severity of asthma: **Not severe - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10- Severe**

3. What triggers your child's asthma attacks? (Please check all that apply)

_____Illness	_____Animals
_____Emotions	_____Smoke
_____Weather	_____Exercise
_____Fatigue	_____Food(s)
_____Chemicals/odors	_____Other_____

4. Allergies (Please List)_____

5. What does your child do at home to relieve symptoms during an asthma attack?

_____Breathing Exercises	_____Inhaler
_____Rest/Relaxation	_____Nebulizer
_____Drink liquids	_____Oral Medications
_____Other_____	

6. Please list the medications that your child takes for asthma. Include name, dose and frequency.

_____

_____

7. What, if any, side effects does your child have from medication?_____

8. How many times has your child been hospitalized overnight or longer for asthma in the past year?_____

9. How many times has your child been treated in the emergency room in the past year?_____

10. Is there any other information that you feel the school should know regarding your child's health?_____

_____

**********I have read and agree that the completed information should be followed in the event that my child has an asthma attack at school and that I am responsible for ensuring that emergency medication is available for my child. This includes when my child is at school, going to and from school, and while on field trips. I understand that I must provide a completed authorization medication form for any necessary medications before they can be given at school.

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

❑ Medication/Physician Orders (Health Office/File)

School:_____ Phone:_____ Fax: _____

The following received copies and/or trained to initiate the above plan:

Parent/Guardian_____ Health Office _____ Para/Aide _____ Bus Garage _____

Teacher_____ Coach _____ Other_____

****Plan must be completed and signed annually*** **Renewal Date:**_____