Grand Forks Public Schools

Photo of child

NAME:_____
Date of birth: _____ Gender: M F Teacher: _____
School: _____ Grade: _____

ASTHMA EMERGENCY CARE PLAN

Person to contact	Relationship	Primary Phone	Secondary Phone
1.			
2.			
3.			
Physician Treating Student for Asthma:			**Phone:**
CIRCLE factors that may cause an asthma episode: cold weather, cigarette smoke, dust mites, exercise, respiratory infection, strong odor, pollens, mold, foods and/or OTHER:_____			

IF YOU SEE/HEAR THIS:

- •Difficulty breathing
- •Wheezing
- •Shortness of breath
- •Coughing
- •Chest tightness
- •Symptoms with play, exercise or other daily activities

DO THIS:

- •Stay with student, speak softly, and stay calm
- •Keep person sitting upright and encourage slow, deep breathing-in through nose and out through lips
- •Give sips of water
- •Give quick-relief medication as order
  Name and Location of medication: _____
- •Other: _____

CALL 911 IF:

- •No relief from medication
- •Continuous spasmodic coughing
- •Trouble walking or talking
- •Lips or fingernails turning (darkening) gray or blue
- •Increased anxiety or confusion
- •Grunting respirations
- •Restlessness
- •Exhaustion
- •Neck muscles tighten

Administer CPR if breathing stops! Continue until paramedics arrive!

Current medications: _____
_____

☐ My child has my permission and a physician's order to carry his/her inhaler during the school day.

☐ I want this Asthma Emergency Care Plan implemented for my child in school. I give my permission for exchange of confidential information contained in the record of my child between the school nurse and physician. My signature is an informed consent to share this medical information with school staff as a need to know for academic success and emergency plan as determined by the school nurse.

Physician Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____