# ASTHMA
# Emergency Care Plan/504

| | | | |
|---|---|---|---|
| Student Name: | | | |
| DOB: | | Grade: | |
| School: | | Year: | |
| Teacher: | | | |

Transportation: Walk ☐ Car ☐ Bus ☐

| | | | |
|---|---|---|---|
| Address: | | Primary Phone: | |
| Guardian 1 Name: | | Cell: | |
| | | Work: | |
| Guardian 2 Name: | | Cell : | |
| | | Work: | |
| Physician: | | Phone: | |
| Daily Medication: | | Allergies: | |

☐ Inhaler at School Inhaler Location: ☐ Health Room ☐ On Student: - May self-administer

☐ Nebulizer at School

**HEALTH CONCERN:** (Enter asthma diagnosis here)

| | |
|---|---|
| Asthma History | ☐ On daily asthma medication (note above on Daily Medication).<br>☐ Hospitalized overnight for asthma in past 3 years.<br>☐ Intubated for asthma attack.<br>☐ Oral steroids for asthma in past 6 months.<br>☐ Asthma related ER visit in past year. |
| Triggers/ Precautions | |
| Medications at school | Medication:<br>Dosage: |

**EMERGENCY INTERVENTION**

| Moderate Symptoms | Immediate Response |
|---|---|
| * Excessive coughing | * Accompany student to health room **(do not send alone)** |
| * Wheezing | * Give medication as prescribed by LHCP |
| * Shortness of breath | * Guide student to inhale medication slowly and fully |
| * Chest tightness | * Keep student sitting up and reassure student |
| * Nostrils flaring | * Encourage to relax and take deep slow breaths |
| * Shoulders hunched over | * Stay with student until improvement noted |
| * Anxious or scared | Contact the school nurse or parent if no improvement after 15-20 minutes. |
| Additional Student Information: | Additional Student Information: |
| | |
| (Not all students will experience all symptoms during an asthma attack) | |

| Student Name: | | ASTHMA ECP/504 | Age: | | Grad Year: | |
|---|---|---|---|---|---|---|

## EMERGENCY INTERVENTION- continued

| Severe Symptoms | Immediate Response |
|---|---|
| * Lips or nail beds turning gray or blue (students with light complexions)<br><br>Paling of lips or nail beds (students with dark complexions) | * ***CALL 911*** |
| * Grunting | * *Notify parent,* |
| * Inability to speak in complete sentences without taking a breath | * *Notify school nurse* |
| * Severe restlessness | * *Notify principal* |
| * Decreasing or loss of consciousness | * *Do not leave the student unattended* |
| Additional Student Information: | Additional Student Information: |
| | |

## Classroom Accommodation/Modifications

**Report concerns to parent for physician follow-up**

## 504 CONSENT

☐ I acknowledge the evaluation and accommodation plan here provided, and have received a copy of Section 504 Parent/Student Rights.

**EMERGENCY CONTACTS**

| | Name | Phone | Relationship |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

| Parent Signature: | | Date: | |
|---|---|---|---|
| School Nurse : | | Date: | |

A copy of the Health Care plan will be kept in the school office and copies will be given to all District staff members involved with the student.