


ASTHMA - School Emergency Care Plan

	Student Name: Student Name	DOB: Student Date of Birth	No Image Available
		Age: Student Age	
	School: Student School Name	Grade: Student Grade	
	Teacher: Student Advisor		
Health Care Provider: _____ Phone: _____			
Preferred Hospital: _____ Walker/Driven: <input type="checkbox"/> Buser: <input type="checkbox"/>			
Bus #: _____ Bus Driver: _____			

ASTHMA DIAGNOSIS:

Triggers and Allergies:	<input type="checkbox"/> cold/flu <input type="checkbox"/> exercise <input type="checkbox"/> weather <input type="checkbox"/> pollen <input type="checkbox"/> mold <input type="checkbox"/> smoke <input type="checkbox"/> animals <input type="checkbox"/> dust mites <input type="checkbox"/> food <input type="checkbox"/> other: _____
Special Precautions:	_____
Severe allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Severe allergy to: Asthma symptoms can be the caused by a severe allergic reaction!

EMERGENCY INTERVENTION

Yellow Zone	Immediate Response	TIME Initials
<ul style="list-style-type: none"> Excessive coughing Wheezing Shortness of breath Chest tightness Nostrils flaring Anxious or scared Peak Flow _to_ _ <p>(Not all students will experience all symptoms during an asthma attack)</p>	<ul style="list-style-type: none"> Accompany student to health room (do not send alone) Give Yellow Zone medication: Guide student to inhale medication slowly and fully Keep student sitting up and reassure student Encourage to relax and take deep slow breaths Encourage student to drink warm water Stay with student until improvement noted <p>Contact the school nurse Contact parent if no improvement after 15-20 minutes</p>	
Red Zone	Immediate Response	TIME Initials
<ul style="list-style-type: none"> Very short of breath Ribs visible when breathing Trouble walking or talking Severe restlessness Decreasing or loss of consciousness Peak Flow _to_ _ 	<p>CALL 911!</p> <p>Give Red Zone medication:</p> <ul style="list-style-type: none"> Notify parent Notify school nurse Notify principal Do not leave the student unattended 	
Exercise/PE Pre-treatment	Give pre-treatment medication:	

School Nurse RN: _____	IHP Written By _____	Date: Today
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A copy of this plan will be kept in the school office and copies will be given to:

<input type="checkbox"/> Para Pro	<input type="checkbox"/> Trans	<input type="checkbox"/> Teacher	<input type="checkbox"/> PE	<input type="checkbox"/> Student Services	<input type="checkbox"/> Health Room	<input type="checkbox"/> Other : _____	<input type="checkbox"/> Sec- Principal
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Guardian Signature: _____ Date: _____

Guardian 1:	Name: Guardian(s) Primary Hm Phone: Guardian Primary Phone	Cell Phone:	Guardian Primary Cell Phone
Guardian 2:	Name: Guardian(s) Secondary/Wk Work Phone: Guardian(s) Secondary Work Phone	Cell Phone:	Guardian Secondary Cell Phone