# HARRISON COUNTY SCHOOL DISTRICT
# ASTHMA EMERGENCY ACTION PLAN

*Plan valid for one school year*

| STUDENT INFORMATION | | |
|---|---|---|
| **Student Name:** | **Date of Birth:** | **Date of Plan:** |
| **School:** | **Grade:** | **Teacher:** |
| **Address:** | | |

| EMERGENCY CONTACTS | |
|---|---|
| **Parent/Guardian Name(s):** | **Phone Number(s):** |
| **Name/Relationship:** | **Phone Number:** |
| **Name/Relationship:** | **Phone Number:** |
| **Physician's Name:** | **Phone Number:** |

**THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER (MD, NP, PA)**

**Diagnoses:**

**Asthma medication & purpose:**

**Prescribed dosage/time:** **(Expected) Time frame medication should be taken:**

**Circumstances for administration/Indicate number of times medication can be repeated:**

**PLEASE CHECK THE FOLLOWING THAT APPLY:**

- ☐ This student should be allowed to carry this medication by him/herself.
- ☐ This student should be allowed to carry this medication but will need supervision by a school nurse or trained personnel to use this medication.
- ☐ This student should NOT be allowed to carry and use this medication by him/herself at school. Medication should be kept in the nurse's clinic and assistance should be provided by the school nurse or trained staff in taking the medication.

| SEVERITY CLASSIFICATION | TRIGGERS | | SYMPTOMS | | EXERCISE |
|---|---|---|---|---|---|
| ☐ **Mild Intermittent** | ☐ **Animals** | ☐ **Infections** | ☐ **Chin/Throat Itches** | ☐ **Headache** | **Medicate before exercise?** |
| ☐ **Mild Persistent** | ☐ **Anxiety** | ☐ **Odors/Fumes** | ☐ **Coughing** | ☐ **Rapid Pulse** | ☐ **Yes** ☐ **No** |
| ☐ **Moderate Persistent** | ☐ **Exercise** | ☐ **Pollen** | ☐ **Difficulty Breathing** | ☐ **Restlessness** | **Exercise modifications:** |
| ☐ **Severe Persistent** | ☐ **Food** | ☐ **Smoke** | ☐ **Dry Mouth** | ☐ **Tight Chest** | |
| | ☐ **Other** | | ☐ **Feeling Weak** | ☐ **Wheezing** | |
| | | | ☐ **Other** | | |

**ACTIONS FOR SCHOOL STAFF TO TAKE:**

1. **If student complains of or shows any of the above symptoms, allow him/her to use the prescribed medication for asthma.**
2. **If respiratory distress is severe, send for the nurse to bring the medication to the student while he/she sits down to rest. If nurse is not available, trained staff should assist with administering the medication.**
3. **Monitor student closely until symptoms are relieved.**

- ☐ This student should pre-treat with medication before exercise. Exercise modifications: ______________________
- ☐ This student should report to the nurse daily at: ____________ for medication.

This student has a Peak Flow Meter personal best of ______________

Readings above ______________ (80%) do not require treatment with rescue medication.

Readings between ______________ and ______________ require treatment with rescue medication.

Readings below ______________ (50%) require immediate treatment and parent contact.

**CALL 911 IF STUDENT:**

1. Has trouble walking/talking due to shortness of breath.
2. Has blueness of lips or fingernails.
3. Is still below 50% of peak flow meter personal best 15 minutes after treatment.
4. Is getting worse despite treatment and parent/guardian cannot be reached.

______________________________ ______________

Healthcare Provider's Signature Date

**FOR COMPLETION BY PARENT OR LEGAL GUARDIAN:**

As the parent/guardian of the above-named student, (check one or both statements below)

☐ I ask that my child be permitted to carry the medication listed above and self-medicate as authorized by myself and my physician. I release Harrison County School District from liability for any injury arising from self-administration by my child.

☐ I ask that assistance by the school nurse or trained staff be provided to my child in taking the indicated medication. Authorization is hereby granted to release this information to appropriate school personnel. I give my permission for the prescribing health care provider named above to release medical information pertaining to this medication to Harrison County School District.

______________________________ ______________

Parent Signature Date

______________________________ ______________

School Nurse Signature Date