COMMUNITY CONSOLIDATED SCHOOL DISTRICT 146

Place child's photo here.

ASTHMA EMERGENCY ACTION PLAN

Name of Student _____D.O.B. _____ Grade: _____

Teacher _____ Will student ride school bus Yes ___ No ___ Bus # _____
Homeroom _____ Team _____
P.E. Days and Times _____

Parent name(s): _____ Home Phone: _____
Mother Cell: _____ Father Cell: _____
Mother Work: _____ Father Work:_____
Emergency Contact: _____ Phone: _____
Physician name: _____ Phone: _____

The following are signs of an asthma emergency:

- **Breathing is hard and fast**
- **Difficulty talking**
- **Blue or gray discoloration of the lips or fingernails**
- **Nasal flaring; ribs showing with each breath**
- **Failure of medication to reduce worsening symptoms**
- **Peak flow < 50% of personal best.**
- _____

****<u>Asthma Emergency Action</u> (to be completed by a physician)****

List Possible Triggers: _____
Personal Best Peak Flow: _____

<u>Steps to be Taken for an Acute Asthma Episode</u>:

1. Call School Nurse at ext._____

2._____

3._____

4._____

5. _____

____ CHECK if student is authorized to carry and self-administer asthma inhaler*.

Physician Signature_____ **Date**_____

Parent/Guardian Signature _____ **Date** _____

Student Signature (if self carries inhaler) _____ **Date**_____
(**Please be sure to put your initials or other identifying mark on your inhaler**).

REFER TO REVERSE OF THIS PAGE FOR CURRENT MEDICATIONS AND EMERGENCY CONTACTS.

List Medications to be given at school:

Name of Medication	Dosage	Time Given

List Medications given at home :

Name of Medication	Dosage	Time

Additional emergency contacts:

1._____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____