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). ☐ Hospitalized overnight for asthma in past 3 years. ☐ Intubated for asthma attack. ☐ Oral steroids for asthma in past 6 months. ☐ Asthma related ER visit in past year.
Triggers/ Precautions	
Medications at school	Medication: 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) 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.