**Sample Emergency Care Plan for Unlicensed School Personnel: ASTHMA**

|  |  |  |
| --- | --- | --- |
| Name: | DOB: | Gender: 🞎 M 🞎 F |
| Teacher/HR: | Grade: | Date: |

|  |  |  |
| --- | --- | --- |
| **Emergency Contact Information** | | |
| **Name** | **Relationship** | **Phone** |
|  | 🞎 Parent/Guardian  🞎 Other- List relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work: |
|  | 🞎 Parent/Guardian  🞎 Other- List relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Asthma triggers for this student** (Except for exercise, please minimize student exposure to triggers when able): | | | | |
| 🞎 Strong Odors | 🞎 Mold | 🞎 Smoke | 🞎 Temperature Changes | 🞎 Animal (Specify): |
| 🞎 Exercise | | | 🞎 Exhaust Fumes | 🞎 Respiratory Infections |
| 🞎 Other (Specify): | | | 🞎 Pest Urine/Droppings | 🞎 Laughing/Crying |

|  |  |
| --- | --- |
| **WATCH**  for any of the following signs of an asthma episode | **TAKE THESE ACTIONS** when you see any of the signs listed |
| * Difficulty walking or talking, whispers * Stops playing or cannot participate in activities * Complains of neck feeling funny or something stuck in their throat or frequent throat clearing * Coughing frequently * Appears anxious or restless * Sits or stands hunched over * Difficulty breathing, gasping, flared nostrils, audible wheezing sounds with breaths * Lips or fingernails are blue or grey | ❒ **Call for Nurse at:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   * Never leave student unattended * Assist at the request and direction of the Supervised Student to take own quick relief medicine, if available * If nurse is not available or if student does not improve after using own medicine – call 911 or call for emergency transportation in accordance with district policy * Notify parent/guardian |

**This plan was developed by the School Nurse (RN) below and reviewed with staff members.**

|  |  |
| --- | --- |
| School Nurse Name: | Date: |
| School Nurse Signature: | Copy to Parent (Optional) 🞎 |
| School Nurse Phone Contact: | |