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

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

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

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| **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 |

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| **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

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

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