



SCHOOL ASTHMA EMERGENCY PLAN

Student's Name: _____ Teacher/Grade: _____ School Year _____

TO BE COMPLETED BY PHYSICIAN

Emergency action is necessary when this student has symptoms such as:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. Peak flow between _____ and _____ or below _____

Steps to take during an asthma episode:

1. Give emergency medication:

A. Bronchodilator (Quick-relief medication):

Name of Medication _____

Purpose: _____

Dosage: _____ When to use _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart

Call 911 or EMS if minimal or no improvement.

B. Other medications/treatments:

Name: _____

Purpose: _____

Dosage: _____ When to use: _____

Additional instructions: _____

2. Seek emergency medical care if this student experiences any of the following:

- No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- Student exhibits:
 - Chest and neck pulled in with breathing
 - Struggling to breathe
 - Stops playing and cannot start activity again
 - Hunched over while breathing
 - Trouble walking or talking
 - Lips or fingernails turn gray or blue

Additional comments and special instructions: _____

Physician Name

Physician's Signature

Phone Number

Date

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with Physician's instructions above. I have completed a Parent/Physician Request for Administration of Medication for each of the medications specified.

Parent/Guardian's Signature

Date

*This emergency plan and prescribed medications must be renewed annually at the beginning of each school year, and as needed during the school year.