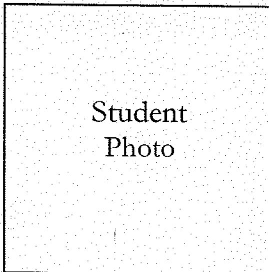
Valley Central School District
Asthma Emergency Health Care Plan



Student: ______________________ Grade: _____ DOB: ____________

Asthma Triggers: ______________________ Best Peak Flow: ______

Mother: ______________ MHome #: __________ MWork #: __________ MCell #: __________

Father: ______________ FHome #: __________ FWork #: __________ FCell #: __________

Emergency Contact: ______________ Relationship: ____________ Phone: ____________

SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:
Changes in breathing: coughing, wheezing, breathing through mouth, shortness of breath, Peak Flow <_______.
Verbal reports of: chest tightness, chest pain, cannot catch breath, dry mouth, "neck feels funny", doesn't feel well, speaks quietly.
Appears: anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

SIGNS OF AN ASTHMA EMERGENCY:
Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling.
Difficulty in walking and talking. Blue-gray discoloration of lips and/or fingernails.
Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment. Peak Flow of ____________ or below.
Respirations greater than 30/minute.
Pulse greater than 120/minute.

TO BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER

TREATMENT:
Stop activity immediately. Notify school nurse at ____________ who will call parent/guardian & health care provider
Help student assume a comfortable position. Sitting up is usually more comfortable.
Encourage purse-lipped breathing.
Encourage fluids to decrease thickness of lung secretions.

Medication ordered: ______________ Dose: ____________ Route: ____________ Frequency: ________

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Special Instructions: ____

Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:
- Call 911 (Emergency Medical Services) and inform them that you have an asthma emergency. They will ask the student's age, physical symptoms, and what medications he/she has taken and usually takes.
- A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present

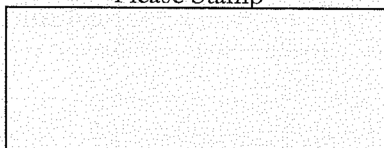
Healthcare Provider: ______________________________ Phone: ______________

Written by: ______________________________ Date: ______________

Parent/Guardian Signature to share this plan with Provider and School Staff: ______________

Health Care Provider Signature ______________________________ Date: __________

Please Stamp



This plan is in effect for the current school year and summer school as needed.

Revised 3/09

Valley Central School District

PROVIDER AND PARENT PERMISSIONS
REQUIRED FOR INDEPENDENT MEDICATION USE AND CARRY

Directions for the Health Care Provider: This form may be used as an addendum to a medication order which does not contain the required diagnosis and attestation for a student to independently use and carry their medication as required by NYS law. A provider **order** and **parent/guardian permission** is needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: ________________________________ **DOB:** ____________________

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that they can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school sponsored activity with no supervision by school staff. This order applies to the medications checked below:

This student is diagnosed with:

- ❑ Allergy and requires Epinephrine Auto-injector
- ❑ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ❑ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ❑ ______________________ which requires rapid administration of ________________
  (State Diagnosis) (Medication Name)

Signature: ________________________________ Date: ____________________

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use their medication effectively and may use and carry this medication independently at any school/school sponsored activity with no supervision by school staff.

Signature: ________________________________ Date: ____________________

Please return to School Nurse:

School Nurse:		School:
Phone #:	Fax:	Email: