ASTHMA Emergency Action Plan

Keller ISD Health Services Department

Name: _____ DOB: _____ Teacher/Grade:_____

Emergency Contact #1:_____ Preferred Contact Number: _____
Emergency Contact#2: _____ Preferred Contact Number: _____
Physician for Asthma: _____ Phone Number: _____
Preferred Hospital: _____

CHECK IF APPLICABLE

Signs and Symptoms	**Triggers**	**What helps your child during an asthma attack?**
☐Wheezing	☐ Exercise ☐Markers	☐Loosen Clothing
☐Difficulty Breathing	☐Cold Air ☐Perfume	☐Administer Medication
☐Chest Tightness	☐Dust ☐Smoke	☐Rest/Relaxation
☐Cough	☐Stress ☐Animals	☐Breathing Exercise
☐Other:	☐Other:	☐Other:
_____	_____	_____
_____	_____	_____

Will student require peak flow monitoring? ☐**Yes** ☐**No** If yes, answer below:
What is the personal best peak flow number? _____
Times peak flow should be checked during school: _____

Please list medications to be administered at school for asthma: *(Medication Authorization form required)*
_____ _____ _____
Will student need a nebulizer at school? ☐**Yes** ☐**No**
Will student carry an inhaler during the school day? ☐**Yes** ☐**No** *If yes, a separate form must be completed by parent/physician. ***An extra inhaler should be kept in school clinic.***

STEPS TO TAKE DURING AN ASTHMATIC EPISODE:

1. Administer authorized medication as directed
2. Monitor student
3. **SEEK EMERGENCY MEDICAL CARE IF STUDENT EXPERIENCES ANY OF THE FOLLOWING:**
   - No improvement after initial treatment with medication and a relative cannot be reached.
   - Student exhibits any of the following:
     - ➢ ***Chest and neck pulled in when breathing. Hunched over while breathing. Struggling to breath. Trouble walking or talking. Lips or fingernails turn cyanotic.***

Parent Signature: _____ Date: _____
Registered Nurse Signature: _____ Date: _____
Licensed Vocational Nurse Signature: _____ Date: _____

☐ Asthma EAP electronically sent via Laserfiche to all staff directly involved with student services. Date: _____