



# South Lyon Community Schools

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Linda M. Raye, Director of Special Services

## Asthma Emergency Care Plan for SCHOOL

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

Grade: \_\_\_\_\_ Room: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Emergency Phone Numbers: \_\_\_\_\_

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Other: \_\_\_\_\_

Physician: \_\_\_\_\_

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This student's asthma is triggered by \_\_\_\_\_.

The following emergency plan is based on physician's recommendations: Child's symptoms usually are (circle all that apply):

1. Wheezing
2. Coughing
3. Child has trouble walking or talking
4. Child stops playing and cannot start again
5. Skin between child's ribs sucks in when breathing
6. Child's fingernails and/or lips turn blue or gray.
7. Other \_\_\_\_\_

### Treatment Plan for Asthma Attack:

1. Remove any known triggers.
2. Help student to sit straight up.
3. Encourage student to take small sips of water.

## Asthma Emergency Care Plan for SCHOOL

Student Name \_\_\_\_\_ Date \_\_\_\_\_

**When the following symptoms are seen:**

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**Name of Medication and Dosage:**

- ◆ If medication has been approved per a physician's order, administer medication.

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**Other Medical Directives:**

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**IF MEDICATION DOES NOT SEEM TO BE WORKING OR IS NOT AVAILABLE NOTIFY SCHOOL OFFICE TO CALL EMS IMMEDIATELY.**

- ◆ Have staff member meet EMS and escort to room.
- ◆ Transport to hospital.

**If symptoms improve:**

- ◆ Give reassurance.
- ◆ Notify school office.
- ◆ Notify parent

Physician Signature \_\_\_\_\_

Parent Signature \_\_\_\_\_

**This information expires on the last day of the school year.**