

# Emergency Care Plan



Sample

## ASTHMA

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Asthma Triggers: \_\_\_\_\_ Best Peak Flow: \_\_\_\_\_

Mother: \_\_\_\_\_ Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

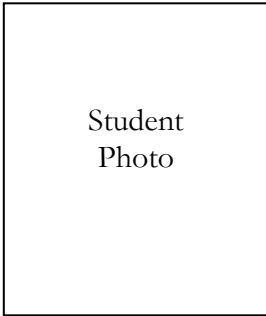
Father: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath
- **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.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

**STAFF MEMBERS INSTRUCTED:**    Classroom Teacher(s)    Administration    Support Staff

### TREATMENT:

Stop activity immediately.  
 Help student assume a comfortable position. Sitting up is usually more comfortable.  
 Encourage purse-lipped breathing.  
 Encourage fluids to decrease thickness of lung secretions.

**\*\*Give Medication:** \_\_\_\_\_ # Puffs: \_\_\_\_\_ Inhaled, Every \_\_\_\_\_ Hours, PRN \_\_\_\_\_  
 Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.

### ASTHMA EMERGENCY:

- Call Hatzalah 718-387-1750 or 718-230-1000 and inform them that you have an asthma emergency. They will ask the student's age, physical symptoms, and what medications he has taken and usually takes.
- Call parent

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Stamp:

**\*\* Physician to complete**

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

Revised 1/08