Date Plan Was Developed: Call School Nurse! Phone

ASTHMA - EMERGENCY CARE PLAN

Is this condition potentially Life Threatening ? Yes ___ No ___

Never send student with any asthma symptoms anywhere alone !!!

Student Name: DOB: Student Picture

Parent/Guardian: Home Phone: Work Phone:

Emergency Contact: Home Phone: Work Phone:

Physician: Phone:

Teacher: Allergies:

Current Medication:

Triggers:

SYMPTOMS of an ASTHMA ATTACK

MILD	MODERATE	SEVERE
Cough Difficulty Breathing	Chest tightness Difficulty Breathing Unusual sounds with breathing (Wheezing) Anxious (look scared) Nostrils flaring Shoulders hunched over	Lips, nails, or mucous membranes are pale, gray, or bluish Rapid pulse (over 120 per minute) Gasping breaths (over 30 per minute) Chest and neck "pulling in" with breathing Severe restlessness Unable to speak in complete sentences without taking a breath Decreasing or loss of consciousness
*Student's usual signs/symptoms	*Student's usual signs/symptoms	*Student's usual signs/symptoms

IF YOU SEE THIS	DO THIS Never send student anywhere alone!!!!!	TIME *Initial*
MILD or MODERATE SIGNS	Medication Located: ______________________ If unable to go to health office, have meds brought to student if necessary Sit student in upright position, if conscious offer water. Instruct to breathe in through nose and out through pursed lips slowly and deeply. Check time of last dose of medication. ***Give ____________ by inhaler or nebulizer _____ hours apart** **Assist student to inhale medication slowly and fully.**	
NO IMPROVEMENT WITHIN 15 MINUTES after medication SEVERE SYMPTOMS	Notify parents. If possible, adult trained in CPR/Rescue Breathing stays with student. **Call 911**	
BREATHING STOPS	Begin CPR.	

Note time of arrival and departure of ambulance; complete this form, initial, and send a copy of form with the ambulance.

Registered Nurse's Signature Date Principal's Signature Date

Parent/Guardian Signature Date Primary Health Care Provider's Signature Date

The following staff members have been given a copy of this Emergency Care Plan: ☐ Parent ☐ Physician ☐ Principal

☐ Teacher(s) ☐ Resource ☐ PE ☐ Music ☐ Library ☐ Transportation ☐ Recess ☐ Office ☐ Other

Our Lady of Mercy School
55 Fourth Avenue, East Greenwich, Rhode Island 02818
Phone: (401) 884-1618 / Fax: (401) 885-3138
Website: www.olmschool.org

Permission to Administer Medication

Student Name: ______________________________ DOB: ______________

Grade: ________ Teacher: ______________

To Be Completed By Health Care Provider

Diagnosis ____

Medication ____________________ Dose ________ Route ________ Time(s) ________

Medication ____________________ Dose ________ Route ________ Time(s) ________

Medication ____________________ Dose ________ Route ________ Time(s) ________

Name and Title of Licensed Prescriber (Please Print) ______________________________

Prescriber's Signature ____________________ Date ________ Phone ____________

To Be Completed By Parent

I give permission for the above medication to be administered to my child as ordered by my health care provider. I will furnish the medication in the original pharmacy container, properly labeled with directions and dosage, or original over-the-counter medication container/packaging with my child's name on it.

Parent/Guardian Signature ____________________ Date ________ Phone ____________

School Nurse: ____________________ School ____________________

Phone: ______________ Fax: ______________ Email ______________