Northampton Area School District

EMERGENCY HEALTH CARE PLAN: ASTHMA

SCHOOL: _____

Student: _____ Grade: _____ Date: _____

Parent/Guardian_____Phone_____Phone_____

Parent/Guardian_____Phone_____Phone_____

Other Emergency Contact_____Phone_____

Physician_____Phone_____

What triggers asthma episode: _____Exercise _____Colds _____Weather change _____Cold Air _____Emotions

_____Irritants _____Molds _____Animal Dander _____Cigarette Smoke _____Odors

_____Pollens _____Dust _____Other:_____

Symptoms of Respiratory Difficulty: (any or all of the following)

*coughing *chest tightness *shortness of breath *blue fingernails/lips/skin *rapid, labored breathing *difficulty conversing

*difficulty walking *decreasing or loss of consciousness *Other_____

Peak flow meter: _____Yes _____No **Spacer:** _____Yes _____No

Instructions for Faculty/Staff:

*Have student stop whatever he/she is doing at onset of symptoms

*Send student to Nurse's Office with another person. Notify nurse of student's arrival.

TREATMENT

INHALER: (Name of medication and directions for use) _____

_____

NEBULIZER: (Name of medication and directions for use) _____

_____

OTHER: _____

LOCATION OF MEDICATION: _____

Can Student Self-Medicate? _____Yes _____No (Requires permission by Physician/Parents)

Does student have permission to carry inhaler on person? _____Yes _____No

Irresponsible or inappropriate use of the inhaler and/or failure to follow the Health Care Plan by the student will require reassessment of the permission to self medicate.

FIELD TRIPS:

Medications (___Yes ___No) and peak flow meter (___Yes ___No) MUST accompany student on all field trips

A copy of this Health Care Plan and current phone numbers MUST be with staff member

Teacher or designee MUST be instructed on correct use of asthma medications

I give my permission for this information to be shared with adults at NASD on a need to know basis. This health care plan will be in effect for the current school year. I understand that it is my responsibility to notify the Health Services office whenever there is a change in my child's health status or care.

_____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature

_____. School Nurse