EDMOND PUBLIC SCHOOLS

Asthma Medical Management & Emergency Action Plan

Student Name: _____ **Date of Birth: _____** **School year: _____**

School: _____ **Teacher: _____** **Grade: _____**

Parent/Guardian: _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

Emergency Contact: _____

Home Phone: _____ Cell/Work Phone: _____

Physician: _____ Phone: _____

Allergies: _____ **Asthma Triggers: _____**

Current Medication: _____

SYMPTOMS OF AN ASTHMA ATTACK

MILD	MODERATE	SEVERE
Cough	Chest tightness	Lips, nails, and/or mucous membranes are pale, gray or bluish
Mild breathing difficulty	Difficulty breathing	Rapid pulse (over 120 per minute
	Unusual sounds with breathing (wheezing)	Gasping breaths (over 30 per minute)
	Anxious (look scared)	Chest and neck "pulling in" with breathing
	Nostrils Flaring	Severe restlessness
		Unable to speak in complete sentences without extra breaths
		Decreasing or loss of consciousness

TREATMENT

MILD	MODERATE	SEVERE
Give _____ by inhaler or nebulizer _____hours or minutes apart.	Complete actions for Mild Treatment	Call 911
Assist student to inhale medication slowly and fully.	If no improvement within 15 minutes, notify parents	If breathing stops, begin CPR
Sit student in upright position, if conscious, offer warm water.		
Instruct to breathe in through nose and out through pursed lips slowly and deeply.		

Other medication instructions: _____

I give permission to the school nurse and other staff members of _____ School to perform and carry out the emergency care tasks as outlined by _____'s Asthma Medical Management Plan. I also consent to the release of the information contained in this Asthma Medical Management Plan to all school staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____

Parent/Guardian Date

Acknowledged and received by:

_____

School Nurse Date

Revised 10/2016