Mequon Thiensville SCHOOL DISTRICT

Emergency Care Plan – Asthma

Student's Photo

Student Name: _____ Birthdate: _____ Grade: _____

School: _____ Teacher:_____ Bus Student: ☐ Yes ☐ No

Guardian Name: _____ Phone: _____ Secondary Phone: _____

Guardian Name: _____ Phone: _____ Secondary Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Physician Name: _____ Phone: _____ Fax: _____

FOR PHYSICIAN / HCP COMPLETION:

SEVERITY: ☐ Student has had many or severe asthma attacks/exacerbations

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

TRIGGERS: Identify the triggers which may start an asthma episode
(Check each that applies to the student).

- ☐ Exercise
- ☐ Carpets in the room
- ☐ Molds
- ☐ Food:_____
- ☐ Change in temperature
- ☐ Strong odors or fumes
- ☐ Pollens
- ☐ Other: _____
- ☐ Animals
- ☐ Respiratory infections
- ☐ Chalk dust/dust

The Colors of a traffic light will guide the school staff in treating the student's asthma at school.

Green means GO Zone! No action needed or pre-treat before activity.

Yellow means Caution Zone! Add quick-relief medicine.

Red means Danger Zone! Get help now

GREEN ZONE

GO! Child takes the following actions daily even when feeling well:

- Breathing is easy
- No cough or wheeze, or only occasionally
- Sleeps well at night
- Can work, play, and exercise

Always use a spacer with inhalers as directed.

☐ Administer Controller Medicine(s) at School (name, route, dose, frequency, time):

☐ Add Rescue Medicine 15 minutes prior to activity (gym, recess, sports) (name, route, dose, frequency, time):

☐ May repeat above dose if needed for continued and/or additional activity (frequency):_____

YELLOW ZONE

CAUTION! Symptoms present. Begin sick treatment plan. Child takes following medications when sick.
DO NOT LEAVE STUDENT UNATTENDED

- Not feeling well
- Some problems breathing
- Mild wheezing
- Frequent cough
- Complaints of chest tightness
- Shortness of breath
- Needs a break from activity
- May have a cold.

☐ Administer Rescue Medication (Name, route, dose, frequency, time):

☐ If no improvement in 10-15 minutes: Repeat above dose of Rescue Medication Continue controller medicines:

☐ As listed in Green Zone
☐ Change to this: _____

☐ Add: _____

Additional Physician Instructions/Comments:

Keep student in health room until symptom-free.**Notify parent/guardian.
If child is in Yellow Zone more than 24 hours or is getting worse, follow Red Zone.
Parent/Guardian to call provider if student is not better in 5 days or sooner if symptoms getting worse.

RED ZONE

DANGER! MEDICAL ALERT. Take these medications and get help now!
DO NOT LEAVE STUDENT UNATTENDED

- Feeling awful
- Breathing hard and fast
- Nose opens wide
- Ribs sticking out
- Can't talk well
- Medicine not helping
- Trouble walking
- Unable to sleep, work or play

☐Administer Rescue Medication **NOW** (Name, route, dose, frequency, time):

If symptoms worsen or no improvement 10-15 minutes after Yellow Zone treatment and relative cannot be reached, call 911.

*Call 911 immediately if the student has any of the following:

- Decrease in level of consciousness
- Chest and neck pulled in with breathing
- Struggling to breathe
- Lips or fingernails gray/blue
- Trouble walking or talking
- Cannot restart activity

Continue to Reverse Side

FOR STUDENTS IN GRADE 9-12 ONLY

PHYSICIAN ONLY:
Please check the appropriate box and sign below

☐ I have instructed this student in the proper way to use his/her inhaled medications. It is my professional opinion that he/she should be allowed to carry and use this inhaled medication by him/herself.

☐ It is my professional opinion that this student should not carry and use his/her inhaled medication by him/herself.

I have reviewed and approve the plan above for this student.

Physician Signature:	Date:

PARENT/GUARDIAN CONSENT:

- I request and authorize that this medication be administered at school by school personnel.
- This student ***(grades 9-12 ONLY)*** is capable of self-administration and may carry medication & self-administer (if physician has approved above). ☐ Yes ☐ No
- This order is in effect for this school year unless otherwise indicated.
- I will supply medication in its original, updated, properly labeled container.
- I will obtain a new physician's order and notify the school in writing of any changes.
- I authorize school personnel to exchange information verbally or in writing with my child's physician regarding this medication or the conditions for which it is prescribed.
- I further understand that parent/guardian/responsible adult should deliver all medication to the school.
- I give my permission to have my child's photo displayed on this form and the school critical health alert form.
- I give permission to designated school personnel to notify other appropriate school personnel and classroom teachers of medication administration and possible adverse effects of the medication.
- I understand that non-medically trained school personnel will give medication.
- I agree to hold the School District, its employees, and agents who are acting within the scope of their duties harmless in any and all claims arising from the administration of this medication at school.
- My signature indicates that I have fully read and understand the above information.

Parent/Guardian Signature:	Date:
District Nurse Signature:	Date: