ARLINGTON PUBLIC SCHOOLS
EDUCATE • PREPARE • INSPIRE

To complete this form electronically, it must be opened in *Adobe Reader*!

Reset Form

Asthma Emergency Care Plan

School year _____

Student legal last name _____ First name _____ MI _____

Birth date _____ School _____ Grade _____ Other ID# _____

Transportation: ☐ Walker ☐ Self Transported ☐ Bus Rider Bus/Route Number _____

Parent/Guardian Information

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Parent/Guardian _____ Primary phone _____

Work phone _____ Cell phone _____

Physician and Hospital Information

Physician Name _____ Phone _____

Preferred Hospital _____ Phone _____

Medical Information

Current Medications (Rescue & Maint.)

Asthma History

Triggers

Special Precautions

Medication Orders

Medication Name _____ Dose _____ When _____

It is medically necessary for this student to carry an inhaler during school hours ☐ Yes ☐ No

Student may self-administer inhaler ☐ Yes ☐ No Student has demonstrated use to Licensed Health Care Professional ☐ Yes ☐ No

Physician's Signature _____ Date _____

Physician's name _____ Phone _____ Fax _____

Emergency Intervention

(Not all students will experience all symptoms during an asthma attack)

Moderate Symptoms	Immediate Response
Excessive coughing	Accompany student to health room (do not send alone)
Wheezing	Give medication as prescribed by IHP
Shortness of breath	Keep student sitting up and reassure student
Chest tightness	Encourage to relax and take deep slow breaths
Nostrils flaring	Encourage student to drink warm water
Shoulders hunched over	Stay with student until improvement noted
Anxious or scared	Contact School Nurse
Peak flow to	Contact parent/guardian if no improvement after 15-20 minutes

Severe Symptoms	Immediate Response
Lips or nail beds turning gray or blue (student with light complexion)	**Call 911**
Paling of lips or nail beds (students with dark complexions)	Notify Parent/Guardian
Grunting	Notify School Nurse
Inability to speak in complete sentences without taking a breath	Notify School Principal
Severe restlessness	**Do not leave the student unattended**
Decreasing or loss of consciousness	

Emergency Contacts

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

Physician Signature _____ Date _____

A copy of this plan will be kept in the school office and copies will be given to:

☐ Para educator ☐ Transportation ☐ Teacher ☐ PE Teacher ☐ Student Services ☐ Health Room ☐ Secretary-Principal

Other _____

CONFIDENTIAL INFORMATION/SHRED PRIOR TO DISCARDING