

Sacred Heart School  
115 Washington Street, Bath, PA 18014  
(610) 837-6391 – Fax (610) 837-2469  
**EMERGENCY HEALTH CARE PLAN: ASTHMA**

Student: \_\_\_\_\_ Grade: \_\_\_\_\_ School Year: 2011-12

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ 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 findernails/lips/skin  
\*rapid, labored breathing \*difficulty conversing \*difficulty walking \*decreasing of loss of consciousness  
\*other \_\_\_\_\_

Peak flow meter \_\_\_ Yes \_\_\_ No Spacer: \_\_\_ Yes \_\_\_ No

**\*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) \_\_\_\_\_

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NEBULIZER: Name of medication and directions for use) \_\_\_\_\_

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OTHER: (Name of medication and directions for use) \_\_\_\_\_

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LOCATION OF MEDICATION: \_\_\_\_\_

Can student self-medicate: \_\_\_ Yes \_\_\_ No (Requires permission from physician in writing)

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:**

Medication ( \_\_\_ 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 the 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 Service office whenever there is a change in my child's health status or care.

\_\_\_\_\_  
Parent's Name Date Physician's Name Date

\_\_\_\_\_  
Parent's Signature Date Physician's Signature Date

\_\_\_\_\_ School Nurse