OUR SHEPHERD LUTHERAN SCHOOL

508 Mentor Ave. Painesville Oh. 44077
Phone: 440-357-7776 Fax: 440-358-1149

Student Photo

Asthma Emergency Action Plan

Student: _____ DOB: _____ Grade: _____

Physical Education Days and times: _____ Recess Time: _____

EMERGENCY INFORMATION:

Parent/Guardian 1 Name: _____ Phone #: _____

Parent/Guardian 2 Name: _____ Phone #: _____

Physician: _____ Phone #: _____

In case of emergency contact:

1. Name: _____ Phone #: _____
2. Name: _____ Phone #: _____

ASTHMA EMERGENCY ACTION:

The following are possible signs of an asthma emergency;

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

These signs indicate the need for emergency medical care. The steps that should be taken:

- Activate the emergency medical system in your area. **CALL 911, PARENT/GUARDIAN, AND DOCTOR**
- Typical Triggers: _____
- Typical Symptoms: _____

☐ **Please check if medication WILL NOT be given at school and parent and physician sign page 2.**

☐ **Please check if medication WILL be given at school, complete the following AND parent and Physician sign page 2**

Name of Medication	Dosage	Time

Steps for an Acute Asthma Episode (to be completed by physician)

1. _____
2. _____
3. _____
4. _____

***** PARENT AND PHYSICIAN SIGNATURE REQUIRED ON PAGE 2 *****

(CONTINUED FROM PAGE 1)

School Transportation: ☐ **Bus Rider** ☐ **Pickup** ☐ **Walker**

☐ **Please check if student requires emergency medication while using school transportation**
Special Considerations for School Transportation: (Example: Student keeps inhaler in book bag.)

_____

Authorization for Release:

I hereby give permission for **Our Shepherd Lutheran School** to exchange specific confidential information with_____(Physician/Clinic) on my child _____ to develop more effective ways of providing for the healthcare needs of my child in school.

Signature of Parent/Guardian _____ **Date** _____

Physicians Name/Location _____ **Phone #** _____

Signature of Physician _____ **Date** _____

*****AUTHORIZATION FOR SELF-MEDICATION WITH ASTHMA INHALER*****

☐ **Please check if STUDENT is <u>permitted by physician</u> to CARRY and SELF-MEDICATE at school.**
<u>Complete the following and</u> parent/guardian and physician must SIGN below:

Date to begin Med: _____ Date to end Med:_____

Adverse reactions that should be reported to physician: _____

Adverse reactions for unauthorized user: _____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack: _____

Other special instructions: _____

_____

<u>Physician and Parent/Guardian Names and Signatures REQUIRED for Self Medication with Asthma Inhaler:</u>

Physician Name: _____Phone #: _____

Signature of Physician: _____Date: _____

Signature of Parent/Guardian: _____Date: _____

Copies must be provided to the principal and to the nurse.