RESURRECTION SCHOOL
946 Boston Post Road
Rye, NY 10580
Tele: (914) 925-3510 Fax: (914) 925-3511

Place Child's Picture Here

ASTHMA
EMERGENCY HEALTH CARE PLAN

Name of Student: _____ D.O.B: ____/____/____ Grade: ____

High risk for severe reaction: **Yes** □ **No** □ (check one)

SYMPTOMS:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath, and respirations greater than 22/minute
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, difficulty in walking/talking
- **APPEARS:** anxious, sweating, nauseous, fatigued, gasping for air, the use of neck muscles when breathing
- **RAPID PULSE:** greater than 120/minute
- Other - _____

**** Stop activity immediately***
**** Help student assume a comfortable position (sitting up is usually more comfortable)***
**** Notify school nurse***

STEP 1: TREATMENT (To be determined by physician)

Inhaler Order: _____
Medications/Dose/Route

Authorization for Self-Directed (Inhaler Only): **Yes/No** (circle one)

He/she is self-directed, has been instructed in the procedure of self-administration and can assume responsibility for carrying his/her own properly labeled medication in the original container. He/she understands the purpose, the correct dose, the possible side effects, and the frequency of use. I request that he/she be permitted to carry his/her own medication, including Field Trips, or to keep own medication in his/her locker. School Nurse has final approval.

Doctor's Signature: _____ Date_____
(Required)
Address: _____ Phone: _____

STEP 2: EMERGENCY ACTION

1. Give medication as prescribed under Step 1: Treatment.
2. CALL AMBULANCE: 911 (Police: (914) 967-1234). Worsening symptoms after initial treatment.
3. CALL: Parent/Guardian _____

I request that my child receive the medication as prescribed above by our physician. The medication is to be furnished by me in the properly labeled original container from the pharmacy. I give permission for my child to receive the prescribed medication as directed and under the supervision of the school nurse or designated other.

I release the Nurse to inform all those (Principal/Faculty/Staff directly involved with the student0 on a "need-to-know" basis all pertinent health information for his/her safety during the school year.
Exceptions: _____

Parent/Guardian Signature_____ Date_____