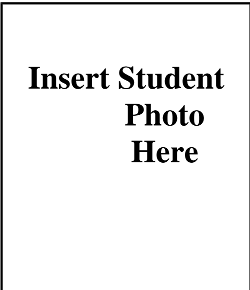

Lubbock Cooper ISD
Asthma
Emergency Care Plan

Date Plan Effective:

Parent to Complete

Name:			Date of Birth:
School / Grade:			Room / Teacher:
Parent / Guardian:			
Mother's phone	Home:	Work:	Cell:
Father's phone	Home:	Work:	Cell:
Health Care Provider:		Phone:	Fax:
Brief history of diagnosis:			
Recent hospitalizations:			

Triggers: (Please check all that apply)

☐ Dust ☐ Chemical odors ☐ Pollen ☐ Mold ☐ Food__________
☐ Animal dander ☐ Cold or Flu ☐ Cold air ☐ Exercise ☐ Other_________

Signs and Symptoms of Asthma	
Mental	Anxious
Mouth	Pale around the mouth
Throat	Chest/neck retracting when breathing
Lungs	Constant difficulty breathing and breathlessness, cough with or without mucous production, wheezing
Heart	Tightness in chest
Other	

Severity of symptoms can change quickly, and rapidly progress to a life-threatening situation!
NEVER SEND STUDENT WITH ANY SYMPTOMS ANYWHERE ALONE

Health Care Provider to Complete

Please indicate if condition is life threatening:

☐ **No**, this condition is not life threatening. No intervention is needed at this time.
(**Thank you for your time. Please sign on back page.)**

☐ **Yes**, this is a life threatening condition. A medication/treatment plan is needed.
(Continue on back page)

Medications to be kept at School and instructions for use:

Inhaler: ____

Nebulizer: ____

Treatment at School, unless otherwise indicated by Health Care Provider:

Basic Management	**Call 911 if:**
• Stay calm and reassure student • Stay with student • Have student use inhaler/nebulizer, per Health Care Provider Order's, if available • Have student drink warm water • Call parent • Call school nurse if not in the building • If improvement takes place, student may return to class after 15 minutes' observation • Other:______________________________	• Chest/neck retracting when breathing • Student is hunched over • Student is struggling to breath • Blue lips or fingernails • Difficulty walking or talking • No improvement 15-20 minutes after using inhaler/nebulizer AND parent cannot be reached • No audible lung sounds • Other:____________________________

Classroom Information/Accommodations:

☐ No ☐ Yes Remain inside during severe cold weather.
☐ No ☐ Yes Remain inside during severe windy/dusty weather.
☐ No ☐ Yes Allow student to set own pace i.e. walk as needed.
☐ No ☐ Yes Allow student to use inhaler (per H.C. Provider's orders)
Other: ____

Field Trip Accommodations or Extra-Curricular Activities Accommodations (as needed):

- All asthma supplies/medication are taken and care is provided:
  ☐ By accompanying parent
  ☐ By the student, if self-managing
  ☐ By accompanying designated school staff per district medication policies and orders

Disaster Planning:

☐ Extra asthma inhaler at school at(location)___________________________________
☐ Other ____

By signing this form, I give my permission for the information on this form to be shared with teachers, principals, and other school personnel that have direct contact with my child.

Parent Signature:	Date:
Health Care Provider Signature:	Date:
School Nurse Signature:	Date:

Date Reviewed with Parent/Teacher:

Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature

Kam 11.04