WARREN WOODS PUBLIC SCHOOLS
ASTHMA EMERGENCY PLAN

Student Name: _____ Birthdate:_____ Grade:_____ School Year:_____

Asthma Triggers (exercise, foods, cold, etc.)**:** _____

Equipment (check all that apply)**:** ___ Medication ___Inhaler ___Spacer ___Nebulizer ___Peak Flow Meter

Note: *By signing this form, if the student will be carrying an inhaler, the school office will be supplied with a backup inhaler.*

Asthma Severity Classification: ☐ **Intermittent** ☐ **Mild Persistent** ☐ **Moderate Persistent** ☐ **Severe Persistent**

☐ **He/She has had many asthma attacks/exacerbations** ☐ **He/She has had severe attacks/exacerbations**

Green Zone - Doing Well

You have all of these:

--Breathing is good

--No cough or wheeze

--Slept through the night

--Can work and play

Control Medication	How Much/Number of Puffs	How Often/When

Physical Activity: Use _____ (medication), _____ puffs, _____ minutes before activity/when you feel you need it (circle one).

Yellow Zone - Caution

You have any of these issues:

--First signs of a cold

--Exposure to known trigger

--Cough and/or cough at night

--Mild wheeze, tight chest

Continue with Green Zone medication and add:

Medication	How Much/Number of Puffs	How Often/When

Red Zone - Danger

Your asthma is getting worse, fast:

-- Medicine is not helping

--Breathing is hard and fast

--Nostrils are opening wide with breaths

--Trouble speaking

Signs of an Asthma Emergency:

No improvement 10-15 minutes after medicine

Breathing difficulty gets worse

Skin pulls in around the collarbone or ribs with each breath

Looks anxious, frightened, or restless

Trouble walking, talking, or is hunched over

Lips or nail beds are blue or gray

Call 911 and Parent/Guardian – Start CPR if breathing stops

Signs of an Asthma Attack:

Wheezing	Prolonged coughing	Inability to speak full sentences
Shortness of breath	Chest tightness or pressure	Only able to whisper
Difficulty breathing	Appears anxious	Feels the need to stand or lean over at the waist

Action:

--Allow student to use his/hers medication as ordered

--Use a spacer is provided for a metered dose inhaler

--Be sure to wait 1-2 minutes before a second puff of the inhaler

--Remain calm and encourage slow, deep breaths

--Breaths should be in through the nose and out through puckered lips

--Have the student sit upright

--Stay with the student until they are breathing normally

--Call the parent

If no medication available:

--Remain calm

--Stay with the student and continuously observe them

--Notify parent to provide medical care

--Call 911 as indicated in "Red Zone"

****

*This portion to be **filled out by authorized prescriber**. Signature indicates agreement with above protocol(s) stated on this plan.*

Medication 1:_____ Route**:**_____ Dose**:**_____ Frequency**:**_____

Special Instructions**:**_____

Medication 2:_____ Route**:**_____ Dose**:**_____ Frequency**:**_____

Special Instructions**:**_____

MDI Treatment may be repeated in _____to_____ minutes if relief is not achieved or symptoms worsen.

Nebulizer instructions (Current infection control guidelines will be followed):_____

Student can use their inhaler correctly, knows when to get adult help, knows not to share, and is able to properly maintain the device. Therefore, in my professional opinion, this student should allowed to self carry their inhaler.

Yes _____ No_____

Peak Flow Readings are to be done at school: Yes_____ No_____ Give medication for a PF Reading below:_____

Personal Best Peak Flow:_____ Other instructions/Orders:_____

Licensed Prescribers Signature**:**_____ Date**:**_____

Licensed Prescribers Name (printed)**:**_____ Phone**:**_____

****

I give written authorization for the medication(s) listed in this plan to be administered, in school, by trained staff members, as appropriate and as ordered. I understand that my child's name may appear on a list with other students who have asthma, in order to better identify needs in an emergency. I agree to send in a backup inhaler for the school office or school nurse to hold on to, if my child is able to self-carry their own inhaler. I consent to communication between the prescribing health care provider/clinic and trained school personnel for clarification of orders and medical information if needed.

Parent Signature:_____ Date:_____ Phone:_____

Emergency Contact 1:_____ Phone:_____ Relation:_____

Emergency Contact 2:_____ Phone:_____ Relation:_____

Sources: Michigan State Board of Education Policy on Management of Asthma in Schools, Allergy & Asthma Network, and Asthma and Allergy Foundation of America.