ASTHMA
Emergency Care Plan/504

School Year

Student Name: **Student Name**
DOB: Student Birthdate
School: School Name
Teacher:

Student Grad Year: Grad Year
Student Grade: Grade
Start Date:
Student Other Id: Other Id

No Image Available

Transportation:	Walker ☐	Car ☐	Bus Rider ☐	Bus Number:	Bus Number

Parent/Guardian:	Guardian(s) Primary	Hm Phone:	Guardian(s) Primary Phone
Guardian 1:	Wk Phone: Guardian(s) Primary Work Phone	Cell Phone:	Guardian(s) Primary Cell Phone
Guardian 2:	Wk Phone: Guardian(s) Secondary Work Phone	Cell Phone:	Guardian(s) Secondary Cell Phone
Physician:		Phone:	
Preferred Hospital:		Allergies:	

Current Medication: _____ Rescue and Maintenance _____

HEALTH CONCERN: (Enter asthma diagnosis here)	
Asthma History	
Triggers	
Special Precautions	

EMERGENCY INTERVENTION

Moderate Symptoms	**Immediate Response**
• Excessive coughing	• Accompany student to health room **(<u>do not send alone</u>)**
• Wheezing	• Give medication as prescribed by LHP
• Shortness of breath	• Guide student to inhale medication slowly and fully
• Chest tightness	• Keep student sitting up and reassure student
• Nostrils flaring	• Encourage to relax and take deep slow breaths
• Shoulders hunched over	• Encourage student to drink warm water
• Anxious or scared	• Stay with student until improvement noted
• Peak Flow to	
Additional Student Information:	Contact the school nurse Contact parent if no improvement after 15-20 minutes
	Additional Student Information:
(Not all students will experience all symptoms during an asthma attack)	

Student Name:	**Student LFM Name**	**ASTHMA ECP/504**	Age:	Student Age

EMERGENCY INTERVENTION- continued

Severe Symptoms	Immediate Response
• Lips or nail beds turning gray or blue (students with light complexions) Paling of lips or nail beds (students with dark complexions)	• ***CALL 911***
• Grunting	• *Notify parent,*
• Inability to speak in complete sentences without taking a breath	• *Notify school nurse*
• Severe restlessness	• *Notify principal*
• Decreasing or loss of consciousness	• *Do not leave the student unattended*
Peak Flow to	Additional Student Information:
Additional Student Information:	

Classroom Accommodation/Modifications Save & Close

Report concerns to parent for physician follow-up

504 CONSENT

☐	I DO ACCEPT this accommodation plan. I am aware that there will be an annual review of plan and periodic evaluations (at least every 3 years). I have received a copy of *Section 504 Parent/Student Rights in Identification, Evaluation and Placement*.
☐	I DO **NOT** ACCEPT this accommodation plan. I am aware that there will be an annual review of plan and periodic evaluations (at least every 3 years). I have received a copy of *Section 504 Parent/Student Rights in Identification, Evaluation and Placement*.

EMERGENCY CONTACTS

	Name	Phone	Relationship
1.	Emer Contact 1 Name	Emer Contact 1 Primary Phone	Emer Contact 1 Relationship
2.	Emer Contact 2 Name	Emer Contact 2 Primary Phone	Emer Contact 2 Relationship
3.	Emer Contact 3 Name	Emer Contact 3 Primary Phone	Emer Contact 3 Relationship
4.			

Parent (required):		Date:	
School Nurse:		Date:	
A copy of this plan will be kept in the health room. It will also be available to:			

Para Pro ☑	Trans ☑	Teacher ☑	Cafeteria ☑	PE ☑	Other :	Sec-Principal ☑