

**ASTHMA/RESPIRATORY CONDITION EMERGENCY CARE PLAN 2015-2016 SCHOOL YEAR
GREENFIELD-CENTRAL COMMUNITY SCHOOL CORPORATION**

Student's Name: _____ Date of Birth: _____

Student's Address: _____

EMERGENCY CONTACTS

<u>Name</u>	<u>Relationship</u>	<u>Telephone</u>	<u>Email</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

TO BE COMPLETED BY THE PHYSICIAN

Please list daily controller medications this student takes:

1. _____
2. _____

Steps to take during episode:

1. Give the following rescue medication (Form 5330F1 must also be completed for school personnel to administer this medication):

Medication Name	Dosage Instructions
-----------------	---------------------

Should the student use a spacer with this inhaler? _____ (yes or no)

2. Have the student return to class if _____
3. Contact parent if _____
4. May repeat above dose in _____ minutes if student has no improvement in symptoms, but contact parent.
5. Call 911 if the student has any of the following:
 - a. No improvement after 15-20 minutes after initial treatment
 - b. Chest and neck pulled in with breathing
 - c. Any respiratory distress
 - d. Stops playing and can't start activity again
 - e. Student is hunched over, has trouble walking or talking
 - f. Lips and/or fingernails are gray or blue
 - g. Other: _____

Student should use this inhaler 15 minutes prior to physical activity (Form 5330F1 must also be completed for school personnel to administer this medication).

This student **Should** **Should Not carry** their own inhaler and use as directed. They have been instructed by me, the physician, on how and when to administer this medication. I advise that in addition to carrying their inhaler, one also be stored in the clinic for use in an emergency situation.

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____ Telephone Number: _____

TO BE COMPLETED BY THE PARENT/GUARDIAN

In addition to the above instructions from the physician, I wish to communicate the following information to school personnel regarding my student:

As the parent/guardian of a student with asthma or a respiratory condition, I understand it is **my** responsibility to inform bus drivers, coaches, extra-curricular sponsors, tutors, etc., of my student's condition.

If the physician has indicated that my student can carry a rescue inhaler, I authorize my student to do so. My student has been instructed on the purpose of and appropriate method and frequency of use of the prescribed medication. He/she also understands the requirement of reporting immediately to the school health assistant if relief is not obtained after one treatment. I understand that it is **strongly advised** that an extra inhaler be stored in the clinic even if my student is authorized to carry their inhaler.

I hereby give permission for the exchange of medical information between the corporation nurse, health assistant, school principal, and the physician listed above. I also give permission for clinic personnel to share this medical information with school staff as needed to help protect my student's safety and well-being.

I agree to and wish to implement this emergency care plan for my student.

Parent/Guardian's Signature: _____ Date: _____

Printed Name: _____

TO BE COMPLETED BY SCHOOL PERSONNEL

Date ECP received by clinic personnel: _____

ECP Reviewed by Health Assistant _____

ECP Reviewed by Corporation Nurse _____