Lackawanna Trail Junior-Senior High School

"Home of the Lions"

ASTHMA EMERGENCY CARE PLAN

Emergency action is necessary when the student has symptoms such as: _____
_____.

Nurse will:

1. Give medications as instructed below.
2. Have student return to class if :_____.
3. Contact parent if: _____.
4. **Contact Emergency Services if the student displays any of the following:**
   a. No improvement 15-20 min. after initial treatment
   b. Peak Flow of _____
   c. Labored Breathing
      - Hunched over
      - Fatigue as a result of labored breathing
      - Pursed lip breathing
      - Strain in chest/neck with inhalation/exhalation
   d. Inability to walk/talk
   e. Cyanosis of fingers/lips

Medication Administration:

Nurse will administer the following medications:

Medication Name	Dosage	Time

Inhaled Medications:

____ I have instructed _____ how to affectively use his/her inhaler. He/She may self administer medication under the supervision of the school nurse. Inhalers are to be kept in the school nurses office unless otherwise specified.

_____
(Physician Signature) (Date)

_____
(Parent Signature) (Date)

PO Box 85
Factoryville, PA 18419

570-945-5181 Fax: 570-945-3832

www.ltsd.org

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ASTHMA ACTION PLAN

Student Information:

Name:_____ D.O.B ___/___/___

Grade_____ Phys. Ed. Days _____ Period _____

Emergency Contact Information:

Parent/Guardian Name(s): _____

Mother: (H)_____ (W)_____

Father: (H)_____ (W)_____

Physican's Name/Phone: _____/ _____

In the event the parents are not able to be reached, whom may we contact?

1. _____/_____
2. _____/_____
3. _____/_____

Asthma Triggers:_____

TREATMENT:

Personal Best Peak Flow Number: _____

All Current Medications:

Medication Name	Dosage	Time

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