MENASHA JOINT SCHOOL DISTRICT

School Health Services

ASTHMA EMERGENCY HEALTH PLAN

Name:______________________________ **D.O.B:**_______________ **School:**_________________________**Grade:**_____

Emergency Contact:____**Phone**:___________________________________

Health Care Provider:______________________________________ **Provider Phone:**____________________________

Trigger of student's breathing emergency (check all that apply)		**Student's inhaler/nebulizer will be kept:**
☐Exercise ☐Strong odors or fumes ☐Respiratory Infections ☐Chalk dust / dust ☐Changes in temperature	☐Carpets in the room ☐Animals ☐Pollens ☐Food ___________________ ☐Molds ☐Other:	☐In school office ☐Student carries own inhaler at school ☐Inhaler/nebulizer not kept at school

SEVERE SYMPTOMS	**PROCEDURE**
Hard breathing with pulling neck and ribs during breaths	1. Administer emergency medication listed below 2. Call 911 3. Notify emergency contacts
Can't walk or talk	
Stops playing and can't start activity again	
Lips or fingernails are grey or blue	

MODERATE SYMPTOMS	**PROCEDURE**
Some problems with coughing, shortness, of breath, wheezing, or chest tightness	1. Administer emergency medication listed below 2. Notify emergency contacts 3. If student has no improvement in 15 to 20 minutes and emergency contact can not be reached, call 911 4. If symptoms become severe, call 911
Can do some, but not all usual activities	

Emergency Medication	**Dosage**	**When to use**

______________________________/______________ __________________________________/_______________

Parent/Guardian Signature Date Physician/HCP Authorization Signature Date

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services with this plan, including the administration of medication to my child. I also hereby authorize the school district staff members to disclose my child's protected health information to all staff, chaperones and other non-employee volunteers at the school or at school events and field trips. I hereby give my permission to school personnel to contact the child's physician if necessary. I understand it is my responsibility to see that the medication is delivered to the school office in the original container and to pick up any remaining medication within one week after the last day of the school year. Medication remaining at school will be discarded.
(4/12/2019)