Whitehall-Coplay School District
Emergency Action Plan (EAP)~Asthma

Student: ___________________________ Date: ___________________________
Teacher/Classroom: ___________________________ Bus: ___________________________
Allergies: ___________________________
List all routine daily medications taken at home (name of medication, dose, and times given):

________________________________________

** Signs of Respiratory Difficulty/Distress **
(any or all of the following)

- Coughing, shortness of breath, wheezing,
- Rapid, shallow, or labored breathing
- Difficulty carrying on a conversation due to difficulty breathing
- Difficulty walking due to breathing problems
- Blueness (cyanosis) of fingernails and lips
- Decreasing or loss of consciousness
- Other ___________________________

** Treatment **

Give:
(medication/dose/route)

Give:
(medication/dose/route)

Give:
(medication/dose/route)

Permission to carry and self administer inhaler: Yes ____ No ____
Peak flow meter: Yes ____ No ____ (Peak flow guidelines on reverse)
Spacer: Yes ____ No ____
Use before exercise/physical activity: Yes ____ No ____

** Emergency Calls **

** Call 9-911 if above signs of respiratory difficulty persist or worsen after treatment.

1. Parent/Guardian: ___________________________

2. Additional Contacts: ___________________________

3. Physician: ___________________________

Parent/Guardian Signature: ___________________________ Date: ____________
Physician’s Signature: ___________________________ Date: ____________
School Nurse: ___________________________ Date: ____________
School personnel informed: ___________________________ Date: ____________

Care Plans are updated yearly and/or throughout the school year as needed.
# Asthma Action Plan

(To be completed by Doctor/Nurse)

Return Color Copy To The School Nurse

<table>
<thead>
<tr>
<th>Name</th>
<th>Birth Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School</th>
<th>Parent/Guardian</th>
<th>Parent's Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor/Nurse’s Name</th>
<th>Doctor/Nurse’s Office Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact After Parent</th>
<th>Contact Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Asthma Severity:  
- □ Mild Intermittent  
- □ Mild Persistent  
- □ Moderate Persistent  
- □ Severe Persistent  

Asthma Triggers:  
- □ Colds  
- □ Exercise  
- □ Animals  
- □ Dust  
- □ Smoke  
- □ Food  
- □ Weather  
- □ Other: __________________________

## TAKE THESE MEDICINES EVERYDAY

**Child feels good:**  
- Breathing is good  
- No cough or wheeze  
- Can work/play  
- Sleeps all night  

Peak flow in this area: __________ to __________

**Green**

<table>
<thead>
<tr>
<th>MEDICINE:</th>
<th>HOW MUCH:</th>
<th>WHEN TO TAKE IT:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:

<table>
<thead>
<tr>
<th>MEDICINE:</th>
<th>HOW MUCH:</th>
<th>WHEN TO TAKE IT:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## IF NOT FEELING WELL

**Child has any** of these:  
- Cough  
- Wheeze  
- Tight Chest  

Peak flow in this area: __________ to __________

**Yellow**

<table>
<thead>
<tr>
<th>MEDICINE:</th>
<th>HOW MUCH:</th>
<th>WHEN TO TAKE IT:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICINE:</th>
<th>HOW MUCH:</th>
<th>WHEN TO TAKE IT:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Call your doctor's office if the symptoms don't improve in 2 days OR if the flare lasts for longer than __________ days. After __________ days go back to GREEN ZONE and take everyday medications as instructed.

## IF FEELING VERY SICK CALL THE DOCTOR OR NURSE NOW!

**Child has any** of these:  
- Medicine not helping  
- Breathing is hard and fast  
- Lips and fingernails are blue  
- Can't walk or talk well  

Peak flow below: __________

**Red**

<table>
<thead>
<tr>
<th>MEDICINE:</th>
<th>HOW MUCH:</th>
<th>WHEN TO TAKE IT:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## TAKE THESE MEDICINES

I give permission to the doctor, nurse, health plan, and other health care providers to share information about my child's asthma to help improve the health of my child.

Parent/Guardian Signature: __________________________ Date: __________

Health Care Provider Signature: __________________________

☐ If is my professional opinion this child should carry his/her inhaled medication by him/herself.
WHITEHALL-COPLAY SCHOOL DISTRICT

Medication Dispensing Form

To the Physician:

Please complete and sign this form if you request your patient to receive a medication during school hours. By signing this form, you are indicating that the student could not attend school unless this medication was available during the school day.

Medication must be brought in the original bottle and will be kept in the health room. It will be the student’s responsibility to request the medication in the health room.

Student’s name: ___________________ Grade: _____ Teacher: ____________________________

Prescribed medication: ________________________________________________________________

Dosage*, route, and frequency: _________________________________________________________

Time of day to be given: _____________________________________________________________

Reason for medication: _______________________________________________________________

Side effects: _______________________________________________________________________

Is child taking any other medication? Name? ______________________________________________

This authorization is in effect from: ______ to: ______ **

☐ Student may carry INHALER / EPIPEN (circle choice) and use as prescribed by licensed provider.

*Licensed Prescriber signature: __________________________________________ Date: __________

Print name of Licensed Prescriber: __________________________________________________

Telephone # of Licensed Prescriber: __________________________________________________

I do hereby release, discharge, and hold harmless, the Whitehall-Coplay School District, its agents and employees, from any and all liability claim for the administration of the above medication to my child and for any and all injuries resulting there from. I consent for employees of Whitehall-Coplay School District to exchange information regarding this medication with the physician who ordered the medication. Please refer to the school calendar for policies related to medications.

Parent/Guardian signature: __________________________________________ Date: __________

*If the dosage is changed at any time, physician must complete new form. Please request additional forms as needed from the school nurse or obtain on-line at www.whitehallcoplay.org.

**This form is only valid for school year in which it was completed.
WHITEHALL-COPLAY SCHOOL DISTRICT

Medication Dispensing Form

To the Physician:

Please complete and sign this form if you request your patient to receive a medication during school hours. By signing this form, you are indicating that the student could not attend school unless this medication was available during the school day.

Medication must be brought in the original bottle and will be kept in the health room. It will be the student’s responsibility to request the medication in the health room.

Student’s name: _______________________ Grade: _____ Teacher: _______________________

Prescribed medication: ____________________________________________________________

Dosage*, route, and frequency: ____________________________________________________

Time of day to be given: __________________________________________________________

Reason for medication: ____________________________________________________________

Side effects: __________________________________________________________________

Is child taking any other medication? Name? __________________________________________________________________

This authorization is in effect from: __________________________ to: __________________________

☐ Student may carry INHALER / EPIPEN (circle choice) and use as prescribed by licensed provider.

*Licensed Prescriber signature: __________________________ Date: __________________________

Print name of Licensed Prescriber: _________________________________________________

Telephone # of Licensed Prescriber: ________________________________________________

I do hereby release, discharge, and hold harmless, the Whitehall-Coplay School District, its agents and employees, from any and all liability claim for the administration of the above medication to my child and for any and all injuries resulting there from. I consent for employees of Whitehall-Coplay School District to exchange information regarding this medication with the physician who ordered the medication. Please refer to the school calendar for policies related to medications.

Parent/Guardian signature: __________________________________ Date: __________________

*If the dosage is changed at any time, physician must complete new form. Please request additional forms as needed from the school nurse or obtain on-line at www.whitehallcoplay.org.

**This form is only valid for school year in which it was completed.