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

Place Child's Photo Here

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)

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(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.*

pennsylvania
DEPARTMENT OF HEALTH

# Asthma Action Plan

(To be completed by Doctor/Nurse)

**Return Color Copy To The School Nurse**

Name | Birth Date | Effective Dat

School | Parent/Guardian | Parent's Phone

Doctor/Nurse's Name | Doctor/Nurse's Office Phone

Emergency Contact After Parent | Contact Phone

**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

| MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: |
|---|---|---|
| | | |
| | | |
| | | |

Green

**Peak flow in this area:**

_____to_____

**20 MINUTES BEFORE EXERCISE USE THIS MEDICINE:**

| | | |
|---|---|---|
| | | |

## IF NOT FEELING WELL

## TAKE EVERYDAY MEDICINES AND ADD THESE RESCUE MEDICINES

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

| MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: |
|---|---|---|
| | | |
| | | |

Yellow

| MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: |
|---|---|---|
| | | |
| | | |
| | | |

**Peak flow in this area:**

_____to_____

*Call your doctor/nurse'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!

## TAKE THESE MEDICINES

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

| MEDICINE: | HOW MUCH: | WHEN TO TAKE IT: |
|---|---|---|
| | | |
| | | |

Red

**Peak flow below:**

_____

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

☐ **It 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.***

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