Whitehall-Coplay School District
Emergency Care Plan (ECP)–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 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: copies are distributed on a need to know:
☐ Classroom teacher ☐ PE ☐ Art ☐ Library ☐ Music ☐ Cafeteria/Recess
☐ Guidance ☐ Office Personnel

Care Plans are updated yearly and/or throughout the school year as needed.
GREEN ZONE - Good control
Peak flow above _______
This is where he/she should be every day
Indicates that student’s asthma is under good control.

* No cough or wheeze
* Tolerating activity easily

Treatment Plan:
1) Daily School Meds: Circle one: Albuteral / Other:
____________________________________________________________________________________
2) Use before exercise/physical activity: Yes ___ No ___
3) Other:____________________________________________________

YELLOW ZONE - Worsening Asthma
Peak flow between ______ and _______
Worsening symptoms

* More short of breath with activity
* Need reliever inhaler more often than usual
* Indicates a warning that student’s asthma may flare
* Vigorous activity should be avoided

Treatment Plan:
1) Reliever inhaler: Circle one: Albuteral / Other:
__________________________________________________________________________________
2) Recheck peak flow 10 minutes after treatment OR May return to class if symptoms or peak flow improved.
3) May repeat inhaler if no improvement in 20 min: Yes _____ No_____
4) Call parent to inform of situation.
5) If student is not improving or getting worse, follow Red Zone plan.

RED ZONE - Danger zone
Peak flow below _______

* Getting little relief from inhalers
* More breathless despite increased medications
* Peak flows do not respond to reliever inhaler/nebulizer

Treatment Plan:
1) Call parent to inform of urgent situation.
2) If symptoms continue to be severe and/or parents aren’t available call 9- 911 immediately
3) Urgent Medications: