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| **Student’s Name:** |  | **Grade:** |  | **Student’s Date of Birth:** |  |
| **School Name:** |  | | **School Address:** |  | |

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| **THIS PERSON HAS A SERIOUS (POTENTIALLY LIFE-THREATENING) ASTHMA ATTACKS** | | | | **ACT QUICKLY; GIVE EMERGENCY MEDICATION IMMEDIATELY** |
| Photo | **Asthma Triggers:** | | | 1. **Give Emergency Medication Instructions:** |
|  | Food(s): |  |  |
|  | Animal(s): |  |
|  | Environment: |  |
|  | Other: |  |
| **Emergency Medication Information:** | | |
| Medication Name: | |  |
| Expiration Date: | |  | 1. **If symptoms worsen or do not improve:** |
| Location: | |  | **➔ CALL 9-1-1** |
| **Previous asthma attack requiring hospitalization**: Person is at greater risk | | | | 1. **Call emergency contact** |
| **Previous Anaphylaxis:** If student has/is having difficulty breathing, give epinephrine auto-injector before asthma medication | | | |

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| **AN ASTHMA ATTACK MAY HAVE THE FOLLOWING SIGNS & SYMPTOMS** | | **EMERGENCY CONTACT INFO:** | | | |
| * Coughing * Wheezing * Tightness or pain in chest * Unable to complete sentences due to shortness of breath | * Fast/shallow breathing * Fear or anxiety * Blue lips or nail beds * Sweating | **Name** | **Relationship** | **Cell Phone** | **Other Phone** |
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*The undersigned parent/guardian authorizes any adult to administer emergency medication following the instructions outlined above to the above-named student in the event of an asthma attack. This protocol has been recommended by the student’s Doctor/Nurse Practitioner. It is the parent/guardian's responsibility to advise the school about any changes to this plan.*

Parent/Guardian Date Doctor/Nurse Practitioner Date