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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