Dallastown Area School District
700 New School Lane
Dallastown, Pennsylvania 17313-9242
(717) 244-4021 Telephone
(866) 337-8119 Facsimile
www.dallastown.net

ASTHMA EMERGENCY ACTION PLAN

Student Name_____ DOB_____ Grade_____ Teacher_____
Preferred Hospital_____
Known Asthma Triggers and Any Required Modifications _____
Known Allergies_____
Additional Health Problems _____
Concurrent Medications_____

Symptoms of an "asthma attack" that may require treatment include any/all of the following:

- Cough
- Wheeze
- Tight chest
- Difficulty breathing
- Inability to work/play
- Difficulty talking
- Sweating
- Anxiety

Symptoms of an "asthma emergency" that may require activation of emergency medical services include any/all of the following:

- Gasping for air
- Pronounced difficulty walking/talking/breathing
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

Steps for an acute asthma episode (**to be completed by physician**)

1. If symptoms mild to moderate, administer the following (medication/dosage/route/instructions):
   _____
   a. Student has permission to self-administer asthma medication and has been taught how/when to utilize appropriately.
   [ ] YES [ ] NO (If YES, parent and student must complete self-administration form. See reverse.)
2. _____
3. _____
4. _____

*If symptoms severe and/or worsening, alert emergency medical services.

Emergency Calls

1. If indicated, Call 911. State that an asthma emergency has been treated.
2. Parent/Guardian _____ Phone Number(s)_____
3. Emergency contact(s)

Name/relation	Phone number(s)
a. _____	_____
b. _____	_____

4. Notify administration.

A staff member should accompany the student to the emergency room if the parent, guardian, or emergency contact is not present.

Healthcare Provider Signature _____ Phone Number_____ Date_____

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/ sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

Parent/Guardian Signature _____ Date_____

*Emergency medications brought into nurse's office will be sent on field trips. Students who self-carry are responsible for supplying medications during all school-sponsored activities. Asthma Emergency Action Plan must be renewed/reviewed annually. Forms must be dated July 1 or later. Emergency medications must be picked up by a parent/guardian by the last day of school each year (if student does not have permission to self-carry).

CSN Reviewed (Initials/Date) _____ Revised 7/2015

To be completed by parent/ guardian, school nurse and student.
Prescribing provider to complete
Asthma and/ or Allergy Emergency Action Plan.

ASTHMA INHALERS and EPINEPHRINE AUTO-INJECTOR SELF-ADMINISTRATION BY STUDENTS

Student's Name _____ Grade _____ Date _____

To self medicate, the student must be able to: (check all that apply)

_____ 1. Respond to and visually recognize his/her name.
_____ 2. Identify his/her medication.
_____ 3. Demonstrate the proper technique for self-administering his/her medication.
_____ 4. Sign his/her medication sheet to acknowledge having taken the medication.
_____ 5. Demonstrate a cooperative attitude in all aspects of self-administration of medication.

Name of Medication _____ Dosage _____ Frequency _____

The above named student has demonstrated the ability to self-administer the physician-prescribed (check one) ___asthma medication or ___ Epinephrine Auto-injector as indicated by the criteria listed above.

Date _____ Signature (Certified School Nurse) _____

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/ sharing of the above named medication will result in the immediate confiscation of the Epinephrine Auto-injector or inhaler and loss of privilege to self-administer if the medication policy is violated.

Date _____ Parent/Guardian Signature _____

I agree to be solely responsible for my asthma inhaler or Epinephrine Auto-injector and to follow the directions for its use as ordered by my physician, as well as the district's medication policy. I am aware that any abuse of this privilege will result in the confiscation of my inhaler or Epinephrine Auto-injector.

Date _____ Student's Signature _____