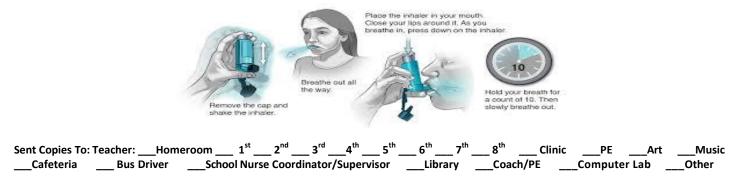
SUMTER COUNTY SCHOOLS HEALTH SERVICES		Grade	Teacher		Date Initiated	
EMERGENCY ACTION PLAN – ASTHMA		Grade	Teacher		Date Reviewed	
(To be completed by Registered Nurse) SCHOOI		Grade	Teacher		Date Reviewed	
Condition: ASTHMA.	ength of time condition ha	s existed		·	Date Discontinued	
Name:						
Parent #1:				Phone #2	2:	
Parent #2:					2:	
Emergency Contact #1:						
Emergency Contact #2:						
Physician Name:						
Specialist Name:						
Severity Classification: Intermitte	ent 🗌 Mild Persistent		lerate Persis	tent 🗌	Severe Persistent	
Identify the triggers an asthma ep Exercise Respirato Animals Temperat	ry Infections	oplies to str ollen Aolds		Smoke Dust	☐ Food ☐ Other	
Peak Flow Monitoring						
Personal Best Peak Flow Number	: Monit	oring Time	s:		PRN	
Equipment supplied by parent:						
ALLERGIES TO:						
Medications at School				Me	edication Storage Location	
Name	Amount	When to	use			
Inhaler					Clinic/Health room	
Nebulizer					Classroom	
Other					Self-Carry/Backpack	
Other					Other	
Description: Asthma is a chronic lung disc	ease which is characterized b	by attacks of k	preathing diffic	ulty. It is ca	used by spasms of the muscles	
around the airways and inflammation an	d increased mucus formatio				airflow in the lungs.	
SYMTOMS:			ACTIONS TO TAKE:			
- Shortness of breath			- Administer prescribed medication			
- Noisy breathing/wheezing			- Do not leave student unattended			
- Excessive coughing			- Keep student upright and encourage to SLOWLY			
- Complains of tightness/pressure in chest			breath in through and out through mouth			
- Lips and fingernail are gray or blue			- Offer student water			
- Breathing difficulty/hunched over			d triggers			
- Trouble walking and talking			00			
- Stops playing and can't start activity again			MANAGEMENT OF RESPIRTORY DISTRESS			
- No improvement 15-20 minutes after treatment			- Call 911			
			- Notify administration, nurse, and parents			
		- Othe	v		and par cities	
		I				



Student Name	DOB			
* As parent/guardian by signing this Health Care Plan, I authorize designated Sum School personnel, and any other contracted health care agencies to provide emerginformation as necessary to support the education and continuity of care of my chinformation with faculty/staff who are directly involved in my child's education.	gency care for my child and/or to share or exchange medical			
Parent Signature	Date			
Obtained via telephone interview with parent	School Year			
Nurse Signature and Date	School Health Tech Signature and Date			
Teacher Signature and Date	Teacher Signature and Date			
Other Faculty/Staff (Specify) and Date	Other Faculty/Staff (specify) and Date			
*YEAR 2 REVIEW: Update to Individual Emergency Action Plan	School Year			
Status determined by:				
 Person-to-person interview Telephone interview Update letter No changes to current plan 				
Parent Signature and Date	Nurse Signature and Date			
Teacher Signature and Date	Other Faculty/Staff (Specify) and Date			
*YEAR 3 REVIEW: Update to Individual Emergency Action Plan	School Year			
Status determined by:				
 Person-to-person interview Telephone interview Update letter No changes to current plan 				
Parent Signature and Date	Nurse Signature and Date			
Teacher Signature and Date	Other Faculty/Staff (Specify) and Date			

*Note: 1. Significant changes to the plan of care requires a new Individual Emergency Action Plan be completed. 2. At the beginning of the 4th school year based on the initial date of this plan a new EAP will bewritten.