

SUMTER COUNTY SCHOOLS HEALTH SERVICES

EMERGENCY ACTION PLAN – ASTHMA

(To be completed by Registered Nurse) **SCHOOL** _____

Grade _____ Teacher _____ Date Initiated _____

Grade _____ Teacher _____ Date Reviewed _____

Grade _____ Teacher _____ Date Reviewed _____

Condition: ASTHMA. Length of time condition has existed _____ Date Discontinued _____

Name: _____		DOB: _____	
Parent #1: _____	Phone #1: _____	Phone #2: _____	
Parent #2: _____	Phone #1: _____	Phone #2: _____	
Emergency Contact #1: _____	Phone: _____		
Emergency Contact #2: _____	Phone: _____		
Physician Name: _____	Phone: _____		
Specialist Name: _____	Phone: _____		

Severity Classification: Intermittent Mild Persistent Moderate Persistent Severe Persistent

Identify the triggers an asthma episode (Check all that applies to student)

- | | | | | |
|-----------------------------------|---|---------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Respiratory Infections | <input type="checkbox"/> Pollen | <input type="checkbox"/> Smoke | <input type="checkbox"/> Food |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Temperature Changes | <input type="checkbox"/> Molds | <input type="checkbox"/> Dust | <input type="checkbox"/> Other |

Peak Flow Monitoring

Personal Best Peak Flow Number: _____ Monitoring Times: _____, _____, _____, _____ PRN

Equipment supplied by parent: _____

ALLERGIES TO: _____

Medications at School			Medication Storage Location
Name	Amount	When to use	
Inhaler _____			<input type="checkbox"/> Clinic/Health room
Nebulizer			<input type="checkbox"/> Classroom
Other			<input type="checkbox"/> Self-Carry/Backpack
Other			<input type="checkbox"/> Other

Description: Asthma is a chronic lung disease which is characterized by attacks of breathing difficulty. It is caused by spasms of the muscles around the airways and inflammation and increased mucus formation in the airways resulting in decreased airflow in the lungs.

<p>SYMPTOMS:</p> <ul style="list-style-type: none"> - Shortness of breath - Noisy breathing/wheezing - Excessive coughing - Complains of tightness/pressure in chest - Lips and fingernail are gray or blue - Breathing difficulty/hunched over - Trouble walking and talking - Stops playing and can't start activity again - No improvement 15-20 minutes after treatment 	<p>ACTIONS TO TAKE:</p> <ul style="list-style-type: none"> - Administer prescribed medication - Do not leave student unattended - Keep student upright and encourage to SLOWLY breath in through and out through mouth - Offer student water - Avoid triggers <p>MANAGEMENT OF RESPIRTORY DISTRESS</p> <ul style="list-style-type: none"> - Call 911 - Notify administration, nurse, and parents - Other
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Sent Copies To: Teacher: ___ Homeroom ___ 1st ___ 2nd ___ 3rd ___ 4th ___ 5th ___ 6th ___ 7th ___ 8th ___ Clinic ___ PE ___ Art ___ Music ___ Cafeteria ___ Bus Driver ___ School Nurse Coordinator/Supervisor ___ Library ___ Coach/PE ___ Computer Lab ___ Other

Student Name _____

DOB _____

* As parent/guardian by signing this Health Care Plan, I authorize designated Sumter County School personnel, Sumter County Health Department School personnel, and any other contracted health care agencies to provide emergency care for my child and/or to share or exchange medical information as necessary to support the education and continuity of care of my child. I also give permission for the Sumter County Schools to share this information with faculty/staff who are directly involved in my child's education.

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 be written.