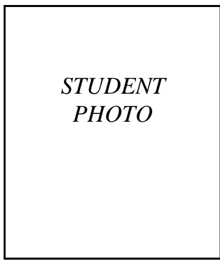

ASTHMA EMERGENCY CARE PLAN

San Francisco Unified School Distirct
Student, Family, and Community Support Department
School Health Programs
1515 Quintara Street
San Francisco, CA 94116-1273
Tel: 415.242.2615 | Fax: 415.242.2618

For School Use Only
Location of Medication: ____________________

TO BE COMPLETED BY PARENT/CAREGIVER

Name: ____ Date of Birth: ____________ School: ___________________

Grade:______ Homeroom Teacher: __________________________ Room: _________

Parent/Caregiver Name: ___________________________ Phone (home): ___________________ (cell):____________

Address: _______________________________________ Phone (work): _____________ Email:___________________

-----------------------------------TO BE COMPLETED BY THE HEALTH CARE PROVIDER------------------------------------

Health Care Provider Treating Student for Asthma:_________________________________ Ph: _________________

Other asthma medication used at home:____

Does student require inhaler before exercise: ☐ No ☐ Yes

If yes, please specify: medication to be given___________________________ and # _____minutes before exercise

ACTIONS TO TAKE

Reduce exposure to the following asthma triggers:

- ☐ Dust/dust mites
- ☐ Cockroaches
- ☐ Pollen
- ☐ Animal fur
- ☐ Smoke
- ☐ Strong smells
- ☐ Temperature changes
- ☐ Having a cold/being sick
- ☐ Mold
- ☐ Air pollution

- **Stay with student, remain calm and speak softly.**
- **Seat student in an upright position.**
- **Encourage slow and deep breaths.**
- **Assist with quick-relief medication:**

  ____
  (name of the medication)
- **If symptoms resolve completely, student may return to class.**
- **Call parent/guardian to inform.**

CALL 911 if student has

- **Difficulty speaking**
- **Flared or enlarged nostrils**
- **Rapid or shallow breathing**
- **Struggling or gasping for breath**
- **Continuous spasmodic coughing**
- **Skin pulling in around neck with breathing**
- **Gray, dusky or bluish color around mouth or under nails**

Administer CPR if Breathing Stops!
Continue Until Paramedics Arrive!

I authorize school personnel to implement this Asthma Emergency Care Plan as described.
I have completed a medication form for the quick relief medication.

_______________________________________ _________________
Health Care Provider Signature Date

I give my consent for school authorities to take appropriate action for the safety and welfare of my child. I give my consent to communicate with the authorized health care provider when necessary.

_______________________________________ _________________
Parent/Caregiver Signature Date