STUDENT PHOTO

ASTHMA EMERGENCY CARE PLAN

For School Use Only
Location of Medication:
_____

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

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.**

I authorize school personnel to implement this Asthma Emergency Care Plan as described.

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 have completed a medication form for the quick relief medication.

_____ _____
Health Care Provider Signature Date

Doy mi consentimiento para que las autoridades escolares tomen la acción apropiada para la seguridad y bienestar de mi hijo/a. Doy mi consentimiento para que las autoridades escolares se comuniquen con el médico de mi hijo/a, cuando sea necesario.

_____ _____
Firma del padre de familia o encargado Fecha