

CARE FOR STUDENTS WITH ASTHMA

Emergency Plan for: _____ **Grade:** _____ **Division:** _____

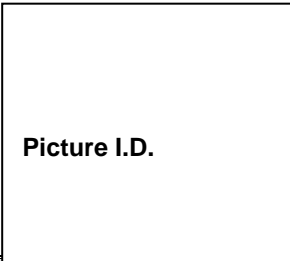
Date of Birth: _____ y/m/d

Emergency Contact: _____
Surname first name

Phone: _____
cell home work

Relationship to Student: _____

Physician: _____



HISTORY

<p>Asthma Triggers Are: (✓)</p> <ul style="list-style-type: none"> <input type="checkbox"/> exercise <input type="checkbox"/> respiratory infections <input type="checkbox"/> change in temperature <input type="checkbox"/> excitement/upset <input type="checkbox"/> strong odors/fumes <input type="checkbox"/> chalk dust <input type="checkbox"/> animals <input type="checkbox"/> pollens <input type="checkbox"/> moulds <input type="checkbox"/> food _____ <input type="checkbox"/> other _____ 	<p>How often does the student experience attacks?</p> <ul style="list-style-type: none"> <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> seasonally <input type="checkbox"/> other: _____ <p>Has emergency medical treatment in a hospital been required for an asthma attack? date: _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> student wears a Medic Alert Bracelet/Necklace <input type="checkbox"/> parent has spoken to teacher regarding child's care <p>Symptoms: (✓)</p> <ul style="list-style-type: none"> <input type="checkbox"/> coughing <input type="checkbox"/> wheezing <input type="checkbox"/> tightness in chest <input type="checkbox"/> short of breath <input type="checkbox"/> pale <input type="checkbox"/> other _____
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EMERGENCY TREATMENT

Medication(s): _____

Medication located: _____

Instructions: _____

**If staff are required to give medication, complete the VSB Administration of Medication Form.*

Call 911 if there is:

- no improvement 15 minutes after initial treatment with medication
- breathing is difficult

Name of person completing form: _____ Parent/ Guardian : Student Other

Date form completed: _____