



Dallastown Area School District

700 New School Lane
Dallastown, Pennsylvania 17313-9242
(717) 244-4021 Telephone
(866) 337-8119 Facsimile
www.dallastown.net

ASTHMA EMERGENCY ACTION PLAN

Student Name _____ DOB _____ Grade _____ Teacher _____

Preferred Hospital _____

Known Asthma Triggers and Any Required Modifications _____

Known Allergies _____

Additional Health Problems _____

Concurrent Medications _____

Symptoms of an "asthma attack" that may require treatment include any/all of the following:

- Cough
- Wheeze
- Tight chest
- Difficulty breathing
- Inability to work/play
- Difficulty talking
- Sweating
- Anxiety

Symptoms of an "asthma emergency" that may require activation of emergency medical services include any/all of the following:

- Gasping for air
- Pronounced difficulty walking/talking/breathing
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

Steps for an acute asthma episode (to be completed by physician)

1. If symptoms mild to moderate, administer the following (medication/dosage/route/instructions):

- a. Student has permission to self-administer asthma medication and has been taught how/when to utilize appropriately.
[] YES [] NO (If YES, parent and student must complete self-administration form. See reverse.)

2. _____
3. _____
4. _____

*If symptoms severe and/or worsening, alert emergency medical services.

Emergency Calls

1. If indicated, Call 911. State that an asthma emergency has been treated.
2. Parent/Guardian _____ Phone Number(s) _____
3. Emergency contact(s)
Name/relation _____ Phone number(s) _____
 - a. _____
 - b. _____
4. Notify administration.

A staff member should accompany the student to the emergency room if the parent, guardian, or emergency contact is not present.

Healthcare Provider Signature _____ Phone Number _____ Date _____

As the parent/guardian of above named student, I relieve the school district and its employees of any responsibility for the benefits or consequences of the above listed medication when it is physician-prescribed and parent/guardian authorized. I further acknowledge that the school bears no responsibility for ensuring that the medication is taken. I am aware that any improper use/ sharing of the above named medication will result in the immediate confiscation of the inhaler and loss of privilege to self-administer if the medication policy is violated.

Parent/Guardian Signature _____ Date _____

*Emergency medications brought into nurse's office will be sent on field trips. Students who self-carry are responsible for supplying medications during all school-sponsored activities. Asthma Emergency Action Plan must be renewed/reviewed annually. Forms must be dated July 1 or later. Emergency medications must be picked up by a parent/guardian by the last day of school each year (if student does not have permission to self-carry).

CSN Reviewed (Initials/Date) _____

Revised 7/2015