

Colquitt County Schools Asthma/Allergy Emergency Health Care Plan

Student's Name _____ DOB _____ Teacher/Grade _____ Parent's Name/Phone# _____

ALLERGY TO: _____
(Complete a separate form for each food allergy that requires special accommodations)

School/Phone# _____
Physician's Name/Phone# _____

Asthmatic? _____ **Yes** _____ **No** _____

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as cough, wheezing, shortness of breath.

*Steps to take during an asthma episode:

1. Check O2 SAT
2. Give medications as listed below.
2. Contact Parent/Guardian
- 4 .Seek emergency medical care if the child has any one of the following:

No improvement minutes after 2nd treatment with Medication
Difficulty breathing with following:

- Chest and neck pulled in with breathing.
- Child hunched over.
- Child struggling to breathe.
- Trouble walking or talking.
- Stops playing and cannot start activity again.
- Lips or fingernails are gray or blue.
- O2 Sat < 90

IF THIS HAPPENS
GET EMERGENCY
HELP NOW!!!

Allergy Emergency Plan

Child is allergic to: _____

* Steps to take during an allergy episode:

- 1.If the following symptoms occur, give medications listed below.
2. If Epi Pen needed, contact 911.
- 3.Contact the child's parent/guardian.

*Symptoms of an allergic reaction include

Mouth/Throat: itching & swelling of lips, tongue mouth, throat;
throat tightness; hoarseness cough.
Skin: hives, itchy rash; swelling
Gut: nausea; abdominal cramps; vomiting; diarrhea
Lungs* shortness of breath; coughing; wheezing
Heart: pulse is hard to detect; "passing out"
*If child has asthma, asthma symptoms may still need to be treated.

Emergency Asthma Medications:

Name	Dosage
Albuterol	Unit Dose .83sol 1vial
Albuterol	Unit Dose MDI 2-3 puffs
Xopenex	Unit Dose .63 mg/ml 1vial

Special Instructions:

CONSENT TO CARRY INHALER

- ☐ I have instructed _____ in the proper way to use his/her inhaled medication. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.
- ☐ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

As parent/guardian of the named student, I give permission for use of this health plan in my student's school and for the school nurse to contact the below named provider(s) regarding the above condition. Orders are valid through the end of the school year. I also give permission for albuterol nebulizer treatments to be given at school per protocol in emergencies.

Emergency Allergy Medication:

Name	Dosage	When To Use
Epi Pen Jr.	.15mg	For all other above listed symptoms
Epi Pen Sr.	.3mg	For all other above listed symptoms
Benadryl	Dose to Weight	If only hives or itchy rash present

Special Instructions:

CONSENT TO CARRY EPI PEN

- ☐ I have instructed _____ in the proper way to use his/her Epi Pen. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.
- ☐ It is my professional opinion that _____ should not carry his/her Epi Pen by him/herself.

Physician's Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____