BLOOMINGTON Public Schools

We help students thrive and dreams come alive

Bloomington Schools Health Services
1350 West 106th Street
Bloomington, MN 55431-4126

Student_____Grade_____

DOB___/___/___School_____

Teacher/Homerm_____ School Year 20___-20___

ASTHMA EMERGENCY HEALTH PLAN

TREATMENT PLAN:

(Green Zone)Normal Breathing Peak Flow _____ to _____

- Breathing easily
- Can play, work and sleep without asthma symptoms
- No action needed

(YELLOW ZONE) EARLY WARNING Peak Flow _____ to _____

- Trouble breathing
- Wheezing
- Tight cough
- Difficulty exhaling
- Feeling tightness
- Anxious

ACTION

1. Remain calm (reassure and stay with student)
2. Have student self administer rescue inhaler if has available. If does not,
3. DO NOT SEND STUDENT TO HEALTH OFFICE ALONE
4. Once in health office, administer medication as ordered
5. Encourage abdominal breathing and offer room temperature water
6. *If no relief of symptoms in 5-10 minutes, **call 911**

(RED ZONE) SEVERE SYMPTOMS / EMERGENCY Peak Flow _____ to _____

- Chest and neck pulled in when breathing
- Trouble walking and talking
- Lips or fingernails blue or gray
- Increased anxiety and confusion
- Loss of consciousness

ACTION

1. Administer emergency medication as ordered (Preferably Nebulizer)
2. **Call 911**
3. Notify parent/guardian

Field Trip Plan _____

_____

CONTACTS

Parent/Guardian_____H#_____W#_____Cell/Pgr#_____

Parent/Guardian_____H#_____W#_____Cell/Pgr#_____

Physician/Clinic_____Phone#_____

Hospital of choice_____

1. **Allergies**:_____

2. **Asthma Triggers** (check all that apply)

- ❑ Cold Air
- ❑ Emotions/Stress
- ❑ Exercise
- ❑ Cigarette or other smoke
- □ Illness
- ❑ Chemical Odors
- ❑ Fatigue
- ❑ Other: list_____

Medications	**Home**	**School**
Name_____ Dose _____ Time _____	☐	☐
Name _____ Dose _____ Time _____	☐	☐
Name _____ Dose _____Time_____	☐	☐

***RESCUE INHALER LOCATION: SELF CARRY_____ HEALTH OFFICE_____ BOTH _____**

***I give health service personnel permission to consult with the above named student's physician regarding any questions that arise about the medical condition and/or medications/treatments ordered.**

***It is recommended that the parent/guardian complete a transportation form from the bus company.**

Parent/Guardian_____Date_____

*Physician Signature_____Date_____
(*only needed if this form is being used as a doctor's order for medications or treatments)

Health Service Personnel_____Date _____

- We ask you to complete this form at the beginning of every school year to ensure that we have the most current information on your child.
- The school district intends to use the requested information to provide for your child's health and safety while at school.
- You may refuse to supply the requested personal information. There will be no consequence for not providing the information. It may result in an incomplete health plan for your child.
- The information you provide will be shared only with staff in the school district whose jobs require access to this information to ensure your child's safety.
- If we are unable to reach you or your designee during an emergency, we will call 911 for assistance if needed.
- I give permission for the school health service staff to consult with my child's physician about any questions regarding the listed medication(s) or medical condition(s) being treated.
- Please contact your school promptly with any changed of information on this form.