Asthma Emergency Action Plan

Child's Name: ______________________ **Grade:**____ **Div:** _____ **Birthdate:**__________

School Name: ______________________ **School Address:**______________________

THIS PERSON HAS A SERIOUS (POTENTIALLY LIFE-THREATENING) ASTHMA ATTACKS

PHOTO

Asthma trigger(s):

- ☐ Food(s): ______________________
- ☐ Animal(s): ______________________
- ☐ Environment: ______________________
- ☐ Other: ______________________

Emergency Medication Information:

Medication Name: ______________________

Expiry Date:___________ Location:____________

☐ **Previous asthma attack requiring hospitalization**: Person is at greater risk

☐ **Previous Anaphylaxis:** If student has/is having difficulty breathing, give epinephrine auto-injector before asthma medication

ACT QUICKLY; GIVE EMERGENCY MEDICATION IMMEDIATELY

1. **Give Emergency Medication Instructions:**

   ____

   ____

   ____

2. **If symptoms worsen or do not improve:**

   ➔ CALL 9-1-1

3. **Call emergency contact**

AN ASTHMA ATTACK MAY HAVE THE FOLLOWING SIGNS & SYMPTOMS

- Coughing
- Wheezing
- Tightness or pain in chest
- Unable to complete sentences due to shortness of breath
- Fast/shallow breathing
- Fear or anxiety
- Blue lips or nail beds
- Sweating

EMERGENCY CONTACT INFO:

Name	Relationship	Cell Phone	Other Phone

The undersigned parent/guardian authorizes any adult to administer emergency medication following the instructions outlined above to the above named student in the event of an asthma attack. This protocol has been recommended by the student's Doctor/Nurse Practitioner. It is the parent/guardian's responsibility to advise the school about any changes to this plan.

Parent/Guardian	Date	Doctor/NP Signature	Date
________________	________	________________________	________

Asthma Emergency Plan is provided as a resource from Vancouver Coastal Health – April 2019
First aid information adapted from www.asthma.ca

VSB Vancouver School Board