



ASTHMA - EMERGENCY CARE PLAN

School Year: March 15, 2024 – September 30, 2025
Yuma School District One



Name: _____ DOB: _____ Grade: _____ Bus: _____

****TO BE COMPLETED BY HEALTHCARE PROVIDER:**

Student May: Self-Carry Self Administer Has Demonstrated to me Proficient use

Medication required during Bus Transport: Yes No Allergies: _____

Take Medication: _____ 15 to 20 minutes before sports or play

GREEN: WELL PLAN

Student feels well
No cough / No wheeze
Can play or exercise normally
Peak flow number is above _____
Personal best peak flow is _____

Use these medicines every day. Remember to use a spacer with inhaler.

MEDICINE	DOSE	HOW TO TAKE	WHEN TO TAKE
_____	_____	_____	_____
_____	_____	_____	_____

YELLOW: SICK PLAN

Student does not feel well
Coughing / Wheezing
Tight Chest
Shortness of breath
First sign of a cold
Peak flow is between _____ and _____

Continue DAILY MEDICATION and ADD:

QUICK RELIEF	DOSE	HOW TO TAKE	WHEN TO TAKE
_____	_____	_____	_____
_____	_____	_____	_____

If needing quick relief medication more than every 4 hours contact the parent.

RED: EMERGENCY PLAN

Student feels awful
Breathing is hard and fast
Wheezing a lot
Can't talk well
Rib or neck muscles show when breathing
Nostrils open wide when breathing
Medicine is not helping

Take quick relief medicine _____

or one nebulizer/breathing treatment every 15 min until you reach a doctor.

Side effects of rescue medication: increased heart rate and jittery feeling.

If rescue medication does not help call 911 and/or contact parent.

Healthcare Provider (print name) _____ Phone: _____

Healthcare Provider (sign) _____ Date: _____

Healthcare Provider Address/Stamp:

TO BE COMPLETED BY PARENT/GUARDIAN

Triggers(circle): Cold Air Colds/Illness Strenuous Exercise Strong Emotions Other: _____

I authorize permission to give this medication to my child. I further authorize the release of all medical information about my child's asthma between the physician's office and school nurse. I agree this plan may be shared with teachers & bus drivers.

Parent/Guardian (PRINT Name) _____ Phone _____

Parent/Guardian (SIGNATURE) _____ Date _____

Emergency Contact _____ Phone _____

RN Signaure _____ Date _____