

**ASTHMATIC REACTION PROCEDURE – PLAN OF CARE**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Grade/House: \_\_\_\_\_

If having asthmatic reaction, student will initially exhibit: ( Please check ✓ as appropriate )

- ( ) Tightness in chest. ( ) Anxious appearance.
- ( ) Shortness of breath. ( ) Need to stand or lean over at waist.
- ( ) Coughing for prolonged periods. ( ) Decreased level of consciousness.
- ( ) Audible wheeze/unusual sounds.
- ( ) Inability to speak in complete sentences without taking a breath/only able to whisper.
- ( ) Bluish discoloration of lips, nails, mucous membranes around eyes/gums.
- ( ) Coughing that causes choking, a bluish color to lips, persistent vomiting.
- ( ) Other \_\_\_\_\_

**PROCEDURE:**

1. Student should be administered his/her asthma medication as below:

Student may go immediately to office/health room accompanied by peer/school personnel.

OR

May call for medication to be immediately brought to the student by school nurse.

OR

( ) Student may carry and self administer medications below: **(MUST CHECK IF APPLICABLE)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Encourage student to relax by:

- Assuming most comfortable position.
- Doing slow, deep breathing.
- Sipping warm water/tea.
- Refocusing on pleasant images/thoughts.

3. Monitor for symptoms above:

- When symptoms decrease 15 minutes after taking medication; student may return to class.
- When symptoms increase in severity or there is absent breathing/pulse/decreased level of consciousness, delegate call to EMS/9-1-1, and begin CPR as necessary.

4. Notify parent of incident and action taken.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date