ASTHMA EMERGENCY CARE PLAN
Minnetonka School District

School: School Health Services
Student Name: Teacher/Team: 
Grade: DOB 

Emergency Contacts:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Home Phone</th>
<th>Work Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Physician: 
Hospital: 

Health Concern: Allergies:

1. Prevention by identifying and avoiding asthma triggers

IDENTIFY ASTHMA TRIGGERS

- Exercise-rarely
- Respiratory Infections
- Change in Temperature
- Animals
- Food
- Other

Green Zone: All Clear

Peak Flow: _________ to _________

AND/OR

- No symptoms of an asthma episode
- Able to do usual activities and sleep without having symptoms

Maintenance Medications:

Yellow Zone: Caution

Peak Flow: _________ to _________

AND/OR

- Coughing
- Wheezing
- Shortness of breath
- Chest tightness
- Unable to perform usual activities
- Sore throat

1. Give medication as listed:
2. Reassess respiratory status, by subjective report or peak flow
3. If no improvement after _______ minutes, call parent/guardian.
   If symptoms progress to Red Zone alert EMS

Red Zone: Medical Alert

Peak Flow: _________ to _________

AND/OR

This is an emergency! Alert EMS

- Coughing
- Shortness of breath
- Chest and neck pulled in with breathing, struggling to breath
- May have trouble talking or walking
- Lips or fingernails are gray or blue

1. Stay with child and reassure until emergency personnel arrive
2. Alert parent/guardian

Rev. 3/16
In case of serious illness and I cannot be reached I authorize school personnel to contact:

Physician/Clinic: 

or transport by ambulance to: 

Hospital

Physician’s orders are required for students to take prescribed medication while at school.

In addition, **specific physician orders are necessary** for a student who needs to carry or chooses to carry their inhaler. Students carrying inhalers must be instructed in the appropriate use by both parents and physicians. We recommend that a back-up inhaler be kept in the health room.

I give permission for my child’s health plan to be shared with pertinent school staff during the current school year. A designation of ECP (Emergency Care Plan) will appear in the alert box found within the Skyward emergency tab.

**Parent Signature:** ___________________________  **Date:** ___________________________

**LSN Signature:** ___________________________  **Date:** ___________________________

*Note: Per school district policy, signed physician prescription, parent authorization, and medication in the original container are required for any medication administration at school. See medication form K-5 or 6-12.*

Medication: ___________________________  Date received in health office: __________

Date physician orders received: ___________________________

Medication: ___________________________  Date received in health office: __________

Date physician orders received: ___________________________