EMERGENCY CARE PLAN FOR ASTHMA

Student _____ **Date** _____

Grade _____ **Date of Birth** _____ **School** _____

Parent/Guardian _____ **Phone** _____ (H)

_____ (C) _____ (W)

Preferred Hospital In Case Of Emergency _____

Physician Name (Print) _____

Physician Signature _____ **Phone** _____

Medical Condition Asthma **Allergies** _____

Non-Emergency Routine Treatment _____

_____

Will the student need a rescue inhaler at school? ☐ Yes ☐ No

Where will the rescue inhaler be kept? ☐ On student (pocket, binder, purse) ☐ In Nurse's office

(Check all that apply) ☐ Locker ☐ Gym Locker

Usual Triggers _____

_____

Signs /Symptoms of Emergency _____

_____

_____

Emergency Treatment _____

_____

I give permission to the principal and to the school nurse to share this "Emergency Care Plan" with school faculty and staff as appropriate. This information will be shared for the purpose of providing first aid or other specific emergency care as described in the plan.

I approve of the above "Emergency Care Plan" and request school personnel to follow the above "Emergency Care Plan" in the event of an emergency involving my child. I will notify the school immediately if my child's health status changes, or there is a change or cancellation of this "Emergency Care Plan." I further agree that the school personnel or nurse may contact the prescriber as needed and that medical information may be shared with school personnel who need to know.

In consideration of this authorization made at our request, the undersigned agrees to indemnify, defend, and save harmless the Board of Education, the individual members thereof and any officials or employees involved in the rendering of care in accord with the above "Emergency Care Plan" from any claims or liability for injury or damages, including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused or to result from the administration of care in accord with the above "Emergency Care Plan."

Parent Signature _____ **Date** _____