Skokie School District 68

Our mission is to develop children who are confident and creative learners. We provide a rigorous curriculum and a supportive school environment that promotes high achievement, encourages personal growth, and meets the unique needs of each child.

SPECIAL SERVICES DEPARTMENT
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EMERGENCY HEALTH CARE PLAN - ASTHMA

Effective School Year: 20 _____ to 20_____ Today's Date:_____

Student's Name: _____ Date of Birth: _____ Grade: _____

Physician's name and phone #: _____

Parent/Guardian #1 name and #: _____

Parent/Guardian #2 name and #: _____

ASTHMA

Description: Asthma is a chronic lung disease which is characterized by attacks of breathing difficulty. It is caused by spasms of the muscles around the airways and inflammation and increased mucus formation in the airways resulting in decreased airflow in the lungs. Asthma may be triggered by allergies, illness, exercise, temperature changes, irritants, or stress.

IF YOU SEE THIS:	DO THIS:
• Wheezing • Increased cough • Shortness of breath • Inability to speak • Tightness or pain in the chest • Choking sensation • Color changes (pale or blue) • Restlessness/anxiety • Signs and symptoms may vary	1. Notify school nurse / health clerk 2. Stay with the student, place in a sitting position, and provide a calm, quiet environment or if student stable, send to health office with another student 3. give medication as ordered by the physician: (med/dose/route): _____ 4. avoid all known triggers 5. avoid over-exertion and emotional excitement 6. offer student tepid water 7. if no improvement, call 911 as per school guidelines 8. school nurse/health clerk will notify parent/principal

TO BE REVIEWED AND SIGNED BY PARENT/GUARDIAN

I give permission to the school nurse/health clerk and other designated staff members of District 68 to perform and carry out the emergency care plan as outlined by this emergency health care plan. I also consent to the release of the information contained in this emergency health care plan to all staff members and other adults who have custodial care of my child and who may need to know this information to maintain my child's health and safety.

_____ _____
Parent Signature Date

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER UPON REVIEW AND APPROVAL

Medications student takes at home: _____

Medication to be taken at school for this condition: _____

_____ _____
Physician signature Date

This form shall be effective for the current school year only, and must be renewed each subsequent school year.