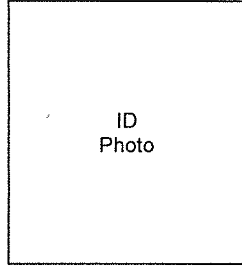
LOWNDES COUNTY SCHOOL SYSTEM
CHILD CARE ASTHMA/ALLERGY ACTION CARD



Name: ____________________

Grade: __________ DOB: __________

Parent/Guardian Name: ____________________

Address: ____________________

Phone (H): __________ (W): __________

Parent/Guardian Name: ____________________

Address: ____________________

Phone (H): __________ (W): __________

Other Contact Information: ____________________

Emergency Phone Contact #1 ____________________
Name

__________ __________
Relationship Phone

Emergency Phone Contact #2 ____________________
Name

__________ __________
Relationship Phone

Physician Child Sees for Asthma/Allergies: ____________________

Phone: ____________________

Other Physician: ____________________

Phone: ____________________

DAILY ASTHMA/ALLERGY MANAGEMENT PLAN

• **Identify the things that start an asthma/allergy episode**

(Check each that applies to the child)

— Animals — Bee/Insect Sting

— Exercise — Latex

___Food: ____________________

___Other: ____________________

• **Control of Child Care Environment** (List any environmental control measures, pre-medications, and or dietary restrictions that the child needs to prevent an asthma/allergy episode.) ____________________

____

- **Daily Medication Plan for Asthma/Allergy**

Name	Dosage	When to Use

- **Outside Activity and Field Trips** The following medications must accompany child when participating in outside activity and field trips:

Name	Dosage	When to Use

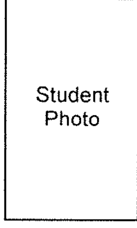
As parent/guardian of the above named student, I give permission for use of this health plan in my student's school and for the school nurse to contact the below provider(s) regarding the above condition. Orders are valid through the end of the current school year.

Physician's Name ____________________ Phone ____________________

Parent Signature ____________________ Date ____________________

(Rev 06/11)

LOWNDES COUNTY SCHOOL SYSTEM
EMERGENCY HEALTH CARE PLAN



Student's Name ______________________ DOB ______________ Teacher/Grade ______________

ALLERGY TO: ____

(Complete a separate form for each food allergy that requires special accommodations.)

Asthmatic? ______ Yes ______ No

ASTHMA EMERGENCY PLAN

Emergency action is necessary when the child has symptoms such as couth, wheeze, shortness of breath

• Steps to take during an asthma episode:

1. Check O_2SAT
2. Give medications as listed below.
3. Contact parent or guardian
4. Seek emergency medical care if the child has any one of the following:

→ No improvement minutes after 2nd treatment with medication
→ Difficulty breathing with following:
➢ Chest and neck pulled in with breathing.
➢ Child hunched over.
➢ Child struggling to breathe.
→ Trouble walking or talking.
→ Stops playing and cannot start activity again.
→ Lips or fingernails are gray or blue.
→ O_2SAT<85

← ***IF THIS HAPPENS, GET EMERGENCY HELP NOW !!*** →

ALLERGY EMERGENCY PLAN

• Child is allergic to: ______________________________

____

• Steps to take during an allergy episode:

1. If the following symptoms occur, give the medications listed below.
2. If Epi needed, contact 911
3. Contact the child's parent/guardian.

• Symptoms of an allergic reaction include

→**Mouth/Throat**: itching & swelling of lips, tongue, mouth, throat; throat tightness; hoarseness; cough
→**Skin**: hives, itchy rash; swelling
→**Gut**: nausea; abdominal cramps; vomiting; diarrhea
→Lung*: shortness of breath; coughing; wheezing
→Heart: pulse is hard to detect; "passing out"
*If child has asthma, asthma symptoms may all need to be treated

• Emergency Asthma Medications:

	Name	Dosage	
	Albuterol	Unit dose .83 sol 1 vial	
	Albuterol	Unit dose MDI 2-3 puffs	
	Xopenex	Unit dose .63 mg/ml 1 vial	

• Emergency Allergy Medications:

	Name	Dosage	When to Use
	Epi Pen Jr.	.15mg	For all other above listed symptoms
	Epi Pen Sr.	.3mg	
	Benadryl	Dose to wt	If only hives or itchy rash present

• Special Instructions:

____

• Special Instructions:

____

CONSENT TO CARRY INHALER

☐ I have instructed ______________ in the proper way to use his/her inhaled medication. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that ______________ should not carry his/her inhaled medication by him/herself.

CONSENT TO CARRY EPI PEN

☐ I have instructed ______________ in the proper way to use his/her Epi Pen. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that ______________ should not carry his/her Epi Pen by him/herself.

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(Rev 06/11)

Physician's Signature ______ Date ______ Parent/Guardian's Signature ______ Date ______ School Nurse's Signature ______ Date ______