EMERGENCY ASTHMA REACTION FORM

Name: _____ Grade: _____ DOB: _____

School: Susquehanna Community

COMMON TRIGGERS MAY INCLUDE (please list):

_____

_____

DURING AN ASTHMA ATTACK, HIS/HER TYPICAL SYMPTOMS ARE (please list):

_____

_____

DOES YOUR CHILD UNDERSTAND THEIR ASTHMA, THEIR SYMPTOMS, AND MANAGEMENT: **YES / NO**

NOTE: Different symptoms may occur and severity of symptoms can change rapidly. A high level of suspicion needs to be maintained for any symptoms exhibited by a student with asthma. **ACT QUICKLY!! IF SYMPTOMS ARE PRESENT OR SUSPECTED, IMMEDIATELY DO THE FOLLOWING**:

1. TREATMENT

_____

_____

_____

2. OTHER DIRECTIONS/RESTRICTIONS/LIMITS FOR THIS STUDENT

_____

_____

_____

Parent/Guardian Emergency Contact Name: _____

Telephone (h) :_____(w):_____(cell):_____

Parent/Guardian Emergency Contact Name: _____

Telephone (h) :_____(w):_____(cell):_____

Alternate Emergency Contact Name/Relationship/Number(s):_____

Healthcare Provider/Telephone: _____

Parent Signature:_____ Date:_____

****** If student will require emergency medication to be available and administered if needed at school, please see and complete the necessary Medication Administration forms. School policy requires all medications to have a written PA licensed provider and parent/guardian order on file, see complete Medication Policy and Self-Use of Asthma Inhaler Policy for more information. ******