

Location of Emergency Medications: \_\_\_\_\_

## ASTHMA INDIVIDUAL HEALTH PLAN

STUDENT \_\_\_\_\_ DOB \_\_\_\_\_ SCHOOL \_\_\_\_\_

GRADE/TEACHER \_\_\_\_\_ SCHOOL YEAR \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ EMAIL: \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ALLERGY SPECIALIST \_\_\_\_\_ PHONE \_\_\_\_\_

1. Briefly describe what causes your child's asthma symptoms (weather, cold, allergies, exercise):
2. How often does your child have to see a doctor or go to the ER for a severe asthma episode? When was the last episode requiring medical attention?
3. Name any medication that your child takes for his/her asthma, how often and how much (including nebulizer treatments):
4. Does your child suffer any side effects from these medications?  - Yes  - No  
Please list them here:
5. Does your child have any physical activity limitations due to his/her asthma?  - Yes  - No  
**Note:** In order to alter school activities, a *physician's order* is required. Please attach a copy of the order to this form.
6. What does student do at home to relieve wheezing during an asthma episode? (Please check any that apply.)  
 Breathing exercises       Inhaler       Rest/relaxation  
 Oral medicine       Drinks liquids       Nebulizer
7. If your child has an asthma episode at school, how do you want the school staff to manage it?
8. Do you know what your child's baseline peak flow rate is?  - Yes  - No  
What is it? \_\_\_\_\_
9. Would you like information about asthma camp (students between the ages of 7-13)?  - Yes  - No

**PLEASE NOTE:** If your student needs medication during the school day, a **Medication Authorization form** must be completed every school year by **you and your child's physician**. These forms may be obtained from your school secretary.

**COMPLETE BACK OF PAGE**

STUDENT'S NAME \_\_\_\_\_

**ASTHMA**  
**EMERGENCY INDIVIDUAL HEALTH PLAN**  
**(For School Staff Use)**

**SIGNS AND SYMPTOMS THAT THE STUDENT MAY EXHIBIT:**

- Excessive or prolonged coughing
- Difficulty breathing
- Wheezing (high-pitched noise heard with breathing)
- Sensation of chest tightness or pain
- Frightened facial expression
- Flaring of nostrils
- Tingling/numbness in fingers/toes
- Loss of color in lips.

**Location of Emergency Medications:** \_\_\_\_\_

**INTERVENTIONS:**

1. Remain with student.
2. Have student rest in a sitting position, breathing slowly through mouth, exhaling slowly through pursed lips.
3. Offer fluids.
4. Refer to student's Emergency Action Plan for further instructions.
5. Have student take prescribed medication, as ordered by physician. **Do not** send anywhere alone to obtain inhaler.
6. Notify school nurse, if in building.
7. Notify parent of severe breathing difficulty or if medication is not effective in 15 minutes.
8. If parent is unavailable or student is having extreme difficulty breathing, call 911 and transport to \_\_\_\_\_ Hospital.
9. Additional instructions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SCHOOL NURSE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_