



# Individual Health Plan Asthma

Student Photo

Grade

Room

Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

**Triggers (circle all that apply):** Dust    Chemical odors    Pollen    Mold  
 Animal Dander    Upper respiratory infections    Cold air    Exercise

Food: \_\_\_\_\_

Other: \_\_\_\_\_

**Symptoms:** *can change quickly and rapidly progress to a life-threatening situation!*

- **Mental:** anxious
- **Respiratory:** chest/neck retracts when breathing, cough wheezing breathless tightness in chest
- **Skin:** pale around the mouth

## Health Care Provider to Complete

- No**, this condition is not life threatening. No intervention is needed at this time.
- No**, this condition is not life threatening. Accommodations are ordered however (see below).
- Yes**, this is a life threatening condition. A medication order and action plan are needed (see below for plan and complete attached medication form).

## Action Plan: If sending student anywhere, send with an escort

Basic Management	Call 911 if:
<ul style="list-style-type: none"> <li>• Stay calm and stay with student</li> <li>• Have student check Peak Flow</li> <li>• Have student use inhaler, per Health Care Provider Order's, if available</li> <li>• Have student drink warm water</li> <li>• Call parent</li> <li>• If improvement takes place, student may return to class after 15 minutes' observation</li> </ul>	<ul style="list-style-type: none"> <li>• Chest/neck retracting when breathing</li> <li>• Student is hunched over</li> <li>• Student is struggling to breathe</li> <li>• Blue lips or fingernails</li> <li>• Difficulty walking or talking</li> <li>• No improvement 15 minutes after using inhaler</li> <li>• No audible lung sounds</li> <li>• Peak flow of less than _____</li> </ul>
<p><b>Instructions from Health Care Provider: (activity, classroom, school bus, field trips, disaster)</b></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes    Remain inside during severe cold weather (able to see breath/or below ____degrees)</p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes    Remain inside during severe windy/dusty weather</p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes    Participate in a group run over a prescribed distance of ____miles.</p> <p>Other: _____</p>	

<b>Health Care Provider Signature:</b>	<b>Date:</b>
<b>Parent Signature:</b>	<b>Date:</b>
School Nurse Signature:	<b>Date:</b>

Date Reviewed with Parent

Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature	Date/Nurse Signature