ASTHMA INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME _____ DOB _____ SCHOOL _____

GRADE _____ TEACHER _____ SCHOOL YEAR _____

PARENT/GUARDIAN _____ BEST CONTACT/PHONE NUMBER _____

PHYSICIAN _____ PHONE _____

ASTHMA SPECIALIST _____ PHONE _____

Please describe what causes your child's asthma symptoms (weather, illness, allergies, exercise, etc.):

Has your child had to go to the ER for a severe asthma episode within the past year? ☐ Yes ☐ No
If yes, please describe:

Does your child take a medication at home every day to keep their asthma controlled? ☐ Yes ☐ No
If yes, what medication?

Does your child have a doctor's order for emergency medication for an asthma attack to be given at school, like a rescue inhaler, and is the medication at school? ☐ Yes ☐ No

In addition to using a rescue inhaler, is there anything else your child does at home that helps with an asthma attack? If yes, please describe:

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's asthma and have knowledge of how to manage an asthma attack. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their asthma.*

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

Is there anything else you would like school staff to know about your child's asthma?

PLEASE NOTE: We recommend an Emergency Action Plan, completed by a doctor, for all children with asthma. Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

☐ I give permission for my child, _____, to receive care for the medical condition listed above by designated school staff.
☐ School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

SCHOOL NURSE SIGNATURE _____ DATE _____

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Emergency: Severe Asthma Attack

STUDENT NAME _____

ASTHMA TRIGGERS _____

Note: If student also has an Emergency Action Plan (EAP) for this condition, please refer to the EAP for actions school staff should take instead. Otherwise, follow the steps below.

This student has an EAP: ☐ Yes ☐ No

Symptoms:

☐ Cough
☐ Shortness of breath
☐ Chest tightness or pain
☐ Wheezing (a high-pitched noise like whistling)

Interventions:

1. Stay with student; student should not leave location or be left alone.
2. Have student rest in a sitting position, breathing in slowly & then exhaling slowly through pursed lips (tightly pressed lips or as if blowing on hot food).
3. Call 911 if needed. Notify front office to direct EMS to student's location.
4. Call or radio for help if needed. Designated first responder school staff should respond to the student's location, and bring any needed emergency equipment.
5. Notify parents/guardians, or designate another staff member to notify:

   Parent/guardian name: _____ Phone number: _____

   Emergency contact name: _____ Phone number: _____
6. Notify school nurse, if in building. If school nurse is not present, notify upon return or via other communication.

Additional information:

_____

_____

_____

_____