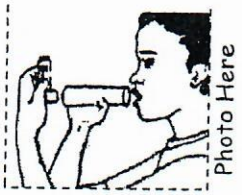
AMERICAN LUNG ASSOCIATION®
of Washington

My Asthma Plan



Name: _____ DOB _____

Parent/Guardian: _____ Phone: _____

Doctor: _____ Phone: _____

Friend/Taxi phone: _____ Peak Flow Personal Best: _____

Asthma Triggers: _____

Food Allergies: _____

For school & child care medication permission: This patient has been instructed in the proper way to take his/her medications. He/she is capable of self-administering medications: Yes No He/she can reliably report asthma symptoms: Yes No

Health Care Provider's Signature: _____ Date: _____ Phone: _____

I Feel Good

- Breathing is good
- No cough or wheeze
- Can work & play

Peak Flow Number
_____ to _____

Prevent asthma symptoms every day:

Medicine:	How much:	When:

20 minutes before exercise or sports, use this medicine:

I Do Not Feel Good

- Cough or wheeze
- Difficulty breathing
- Wake up at night

80% of Personal Best

Peak Flow Number
_____ to _____

CAUTION! SLOW DOWN & take relief medicine:

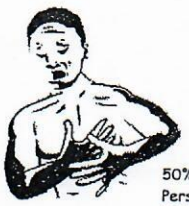
Medicine:	How much:	When:

ALSO CONTINUE/INCREASE your preventive medicine:

Call your doctor if you have these symptoms frequently or if relief medicine does not work!

I Feel Awful

- Medicine not helping
- Breathing hard, fast
- Can't talk/walk well



50% of Personal Best

Peak Flow Number
_____ to _____

MEDICAL ALERT - GET HELP NOW!
Take these medicines until you talk to the doctor:

Medicine:	How much:	When:

Call 911 if your asthma is very severe

Parent Signature: _____ Date: _____

Drawings courtesy of RAMP, Berkeley, CA

INDIVIDUAL HEALTH CARE PLAN

Act 1565 (1999) amends Annotated Arkansas Code 6-18-1005 to require Individualized Health Care Plans for students with special health care needs in schools. (**This information is CONFIDENTIAL.**)

Student's Name _____ Date of Birth _____ Grade _____

School _____ Allergies _____

Student's Diagnosis _____

Brief History on medical condition _____

PROCEDURES AND INTERVENTIONS(TO BE COMPLETED BY PHYSICIAN OR CLINIC NURSE)

1. Does the student require assistance to attend school? _____ If YES, documentation in items 2-10 should support this requirement.

2. Health care treatments, medications, or procedures (i.e. blood sugars, caths) at school:
_____
_____

3. Health care treatments, medications, or procedures at home: _____
_____

4. Potential side-effects of medication(s) or treatment(s): _____

5. Transportation (bus, parent, etc.): _____

6. Suggested environmental modifications (seating in front of room, avoidance of specific allergens, etc.): _____
_____

7. List necessary equipment and supplies and person(s) responsible for providing these items:
_____
_____

8. Safety Measures: _____

9. Dietary requirements: (Certification of disability form must be completed for school to accommodate.): _____

10. Activity Limitations: _____

PLEASE ATTACH A COPY OF STUDENT'S MOST RECENT PHYSICAL EXAMINATION

Physician's Signature _____ **Date Signed** _____

Emergency Plan ( ) Attached ( ) Check if additional information is attached.