**ASTHMA INDIVIDUAL HEALTH PLAN (IHP)**

**\*\*THIS FORM IS VALID FOR SCHOOL DAY, EXTENDED DAY, OVERNIGHT AND WEEKEND FIELD TRIPS**

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| Student: | | | School Year: |
| DOB: | Grade: | School: | |

**□ STUDENT DOES NOT NEED AN ASTHMA HEALTH PLAN AT THIS TIME (Physician signature required below)**

**----------------------THIS SECTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER--------------------------**

ASTHMA TYPE (please check one): € Exercise-Induced € Mild € Moderate € Severe € Reactive Airway Disease

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| ASTHMA TRIGGERS:  € None known € Animals € Cold air € Exercise  € Pollens € Illness € Other:  € Smoke, chemicals, strong odors | USUAL ASTHMA SYMPTOMS:  € Cough € Wheeze €Shortness of breath  € Chest tightness € Asking to use inhaler  € Other: |

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| QUICK RELIEF MEDICATION:  € Albuterol \_\_\_\_\_ puffs (Proair®, Ventolin HFA®, Proventil®) as needed every \_\_\_\_\_ hours for above symptoms.  € Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  € May repeat \_\_\_\_\_ puffs of quick relief medication in \_\_\_\_\_\_ minutes if symptoms have not improved.  € Uses inhaler with spacer.  SIDE EFFECTS INCLUDE: Shakiness, increased heart rate, other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| EXERCISE PRE-TREATMENT  € No exercise pre-treatment needed.  € Give \_\_\_\_\_ puffs of quick relief inhaler \_\_\_\_\_\_\_ minutes prior to: € PE € Recess |
| € **Student may carry/self-administer inhaler and has demonstrated appropriate technique** |

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| IF YOU SEE THIS: | | DO THIS: | | |
| - Wheezing - Coughing - Shortness of Breath  - Complaints of chest tightness | | - Accompany student to health room - Administer inhaler per order  - Keep student sitting up - Encourage student to drink warm fluids | | |
| If symptoms do not improve in 10-15 minutes | | - Notify parent - Repeat inhaler if ordered above  - If parent unable to come within 10 minutes call 911 | | |
| - severe shortness of breath (retractions in ribs)  **-** difficulties walking or talking - bluish lips or nails  - quick relief inhaler not working | | Call 911  Follow emergency procedures | | |
| **Licensed Healthcare Provider Signature:** | Date: | | Printed Name: | Phone/Fax: |

**---------------------------------THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN------------------------------------**

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| Mother/Guardian: | | | Father/Guardian: | | |
| Cell: Work: Home: | | | Cell: Work: Home: | | |
| Emergency Contact: | Relationship: | | | Phone: | |
| **€ Parent agrees that student may carry and self-administer inhaler.**  **\*\*\*If above checked, additional inhaler provided for Health Room € Yes € No** | | | | | |
| Parent/Guardian Signature: | | Printed Name: | | | Date: |

-------------------------------------------------------SCHOOL STAFF SECTION-----------------------------------------------------------

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| Inhaler location: € Health Room € Backpack € Other: |
| Form Received: \_\_\_\_\_\_\_\_\_ € Entered in Database € Exp. Date Checked Rvw’d by District RN: \_\_\_\_\_\_\_\_\_\_\_\_ |