Floodwood School District
Home of the Polar Bears

Childs Name: _____ DOB: _____ Date: _____

Asthma-Individual Health Plan

Asthma Medication(s):

Type	Amount	Administration Time	Frequency

*Will your child need and inhaler at school? _____

*Is your child authorized to carry metered dose inhalers and self-administer in school: _____?

*How severe is your child's asthma? MILD MODERATE SEVERE

*When does your child typically have asthma symptoms? (circle all that apply)

FALL SPRING WINTER SUMMER DAILY WEEKLY MONTHLY OTHER

*What usually triggers your child's asthma symptoms? _____

*What are the early signs that indicate your child is starting to have an asthma attack?

WHEEZING SHORTNESS OF BREATH COUGHING CHEST TIGHTNESS OTHER

*Does your child use a peak flow meter? YES NO If yes, Baseline Reading _____

*ADDITIONAL COMMENTS: _____

_____

Emergency Response Plan:

- Tight Chest → Encourage student to relax
- Wheezing → Notify office
- Coughing/Shortness of breath → Have child use inhaler
- Dry Mouth → Encourage warm fluids
- Sneezing → Slow, deep breaths (in nose, out mouth)
  *If no relief from medications, increased breathing issues occur, call 911 and parent

I give permission for the school to fax this form to my child's doctor for further information or medication orders if needed.

Parent Signature: _____ Date _____

Parent phone number: _____

Physician Name and Clinic information: _____

Physician Signature: _____ Date _____