ASTHMA INDIVIDUAL HEALTH PLAN

Picture

Student:		School Year:
DOB:	Gd:	School:

THIS SECTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER:

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

TYPE: □ Exercised Induced □ Mild □ Moderate □ Severe

QUICK RELIEF MEDICATION:
- □ Albuterol _____ puffs (Proair®, Ventolin HFA®, Proventil®) as needed every _____ hours for above symptoms.
- □ Levalbuterol _____ puffs (Xopenex®) as needed every _____ hours for above symptoms.
- □ Other: _____
- □ May repeat _____ puffs of quick relief medication in _____ (time) 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 to health care provider.**

□ Asthma Action Plan attached

IF YOU SEE THIS	DO THIS
Wheezing Coughing Shortness of breath/dyspnea Complaining of chest tightness	Accompany student to health room Administer Inhaler as above Keep student sitting up and reassure student Encourage student to drink warm fluids
If student's symptoms do not improve in 10-15 minutes	Notify parent Repeat inhaler if ordered above If parents unable to come within 10 min call 911
If student is very short of breath, can see ribs during breathing, difficulty walking or talking, blue appearance to lips or nails, quick relief medication not working	Call 911. Follow emergency procedure checklist

Licensed Health Care Provider Signature:	Date:	Printed Name:	Phone/Fax:

THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN:

Mother/Guardian:			Father/Guardian:		
Hm	Cell	Wk	Hm	Cell	Wk
Emergency contact:		Relationship:		Phone:	

□ Parent/Guardian agrees that student is to 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:

Medication located in: □ Health Room □ Backpack □ Other:

Form Rcv'd:_____ □ Entered in Database □ Exp. Date √ Rvw'd by District Nurse: _____