Individualized Healthcare Plan(IHP)/Emergency Action Plan(EAP) for Student with Asthma

Name____ Date of Birth_____________

Parent/Guardian ____

Phone (w)____________________(h)___________________(c) _____________________

Phone (w)____________________(h)___________________(c) _____________________

Physician_______________________________________Phone_____________________
Fax __________________________

Asthma Severity:

⬜ **Intermittent** ⬜ **Mild Persistent** ⬜ **Moderate Persistent** ⬜ **Severe Persistent** ⬜

Student has had many or severe asthma attacks/exacerbations

Other pertinent history of student's condition:____

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Specifics of Management

Identify the things which may start/trigger an asthma episode. Check each that applies to the student.

- ☐ Exercise
- ☐ Strong odors or fumes
- ☐ Respiratory infections
- ☐ Chalk dust
- ☐ Change in temperature
- ☐ Carpet
- ☐ Animals
- ☐ Pollens
- ☐ Foods
- ☐ Mold
- ☐ Others:__________________

Control of School Environment

List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode:____

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Exercise/Physical Education/Recess Plan:

- ☐ Use inhaler PRN.
- ☐ Use inhaler before PE, then participate normally.
- ☐ Use inhaler before recess, then participate normally.
- ☐ Use inhaler before exercise/activity, attempt moderate participation with frequent walking.
- ☐ Not to participate in extensive running (mile run, pacer fitness run, 12-minute timed run), but will walk instead.
- ☐ Other:____

Peak Flow Monitoring-(if applicable):

Personal best Peak Flow number______________

Monitoring times:____________ _____________ _______________

Daily Medication Plan

Medication/Inhaler	Amount/Dose	Time to be given at school
_____________	________________	________________
_____________	________________	________________
_____________	________________	________________
_____________	________________	________________

_____Student uses an aerochamber or spacer with inhaler.

Emergency Plan:

1. Give emergency asthma medication as listed below.

Emergency Asthma Medications:	Name Amount/Dose	When to Use
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

2. Contact parent or guardian

3. Seek emergency medical care if the student has any of the following:

*No improvement 15-20 minutes after initial treatment with medication and a parent/guardian cannot be reached.

*Oxygen saturation below_________% along with symptoms of respiratory distress.

SYMPTOMS OF RESPIRATORY DISTRESS:

Hard time breathing

Struggling to breath

Chest and neck pulled in with breathing

Student is hunched over

Trouble walking or talking

Lips or fingernails are gray or blue

Special Instructions/Comments:

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Physician Consent for Asthma Management IHP

I have reviewed and approved this asthma management plan and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly. I have instructed this student in the proper use of his/her medications and inhaler.

- ☐ should be allowed to carry and use the inhaler by himself/herself and should report event to the nurse any time after self administering
- ☐ should keep the inhaler in the nurse's office

Physician Signature **Date**

Parent Consent for Asthma Management IHP

- ☐ I, as parent/guardian, concur with the above management plan, will provide the necessary supplies and equipment, notify the school nurse if there is any change in my child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

- ☐ I give permission for my child to self-administer medication for asthma as prescribed by their physician and/or as written in their individual healthcare plan (IHP).

- ☐ I hereby certify that my child has been fully instructed and is capable of self-administration of the medication. I consent to my child carrying, storing and self-administering the medication at school. I acknowledge that I am responsible for providing my child with the medication, properly labeled from the pharmacy, and that I am responsible for any and all monitoring of my child's use of the medication and for any and all consequences of my child's self-administration of medication at school. I will indemnify and hold harmless Grand Island Public Schools, its employees and agents, against any and all claims arising out of my child's self-administration of medication at school, or at a school-related event.

- ☐ I consent to the school nurse storing and/or administering to my child medication in the event that my child is incapable of self-storage and/or self-administration of the medication at school

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Parent/Guardian Signature **Date**