

Individualized Health Care Plan for Asthma

What Starts an Asthma Episode? (Check each that applies to the student.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Respiratory infection |
| <input type="checkbox"/> Changes in temperature | <input type="checkbox"/> Chalk dust | <input type="checkbox"/> Carpet in the room |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Pollens | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Foods _____ | | |
| <input type="checkbox"/> Other(s) _____ | | |

Control of School Environment

List any environmental control measures, dietary restriction, or other items that the student needs to prevent an asthma episode.

Peak Flow

Normal level is _____

What conditions to use on PRN bases? _____

What to do for peak flow readings of different levels _____

Emergency Plan

Emergency Action is necessary when the student has symptoms such as _____

Peak flow reading is _____

Steps to Take during an Asthma Episode (check appropriate steps that apply)

- Check peak flow.
- Give medications as listed above. (Student should respond to treatment in 15-20 minutes.)
- Contact parents/guardians if _____
- Re-check peak flow.
- Seek emergency medical care (911) if the student has any of the following:
 - Coughs constantly.
 - No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
 - Peak flow of _____
 - Hard time breathing with
 - ◆ Chest and neck pulled in with breathing
 - ◆ Stooped body posture
 - ◆ Struggling or gasping
- Trouble walking or talking.
- Stops playing and can't start activity again.
- Lips or fingernails are gray or blue.

Special instructions _____

This "IHCP" may be given to teachers, substitute teacher, and staff.

School Nurse/Representative _____ Principal _____

Teacher _____ Parent _____ Student _____

As appropriate: Coach _____ Before/After Program Coordinator _____

Physician: _____

Reference: *Asthma and Allergy Foundation of American, 1233 20th St, NW Suite 402, Washington, DC 20036 *
www.aafa.org* 1-800-ASTHMA*

Asthma Medication Permission Form

Student's Name _____ Date of Birth _____ Age _____
School _____ Grade _____ Teacher _____
Address/City/Zip _____
Mother/Guardian Name _____ Work/Cell Number _____
Address/City/Zip _____ Home Number _____
Father /Guardian Name _____ Work/Cell Number _____
Address/City/Zip and phone number, if different from above _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PRESCRIBER

Physician's Name _____
Address _____
Phone Number _____ Emergency Number _____
Medication _____
Symptoms when this medication is to be given _____
Dose _____
Frequency _____
Maximum # of doses @ school _____
Peak flow readings _____
Beginning date _____ Ending date _____

Permission for the Self-Administration and Carrying the Asthma Medication by the Student

This child is capable of self-administration of this medication while on school property or school-related events or activities. This means the prescription medication may be used at the student's discretion. Yes ___ No ___

The student may carry the medication. Yes ___ No ___

Physician Signature _____

Date _____

Parent/Guardian

I realize that the school does not have to agree to allow medication to be given to a student by school personnel. I understand that the school's agreeing to allow the medication to be given is for my benefit and the student's benefit. Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston – Houston, its servants, agents, and employees including, but not limited to the parish, the school, the principal, and the individuals giving the medication of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive any and all claims, demands, or causes of action against the Archdiocese of Galveston – Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent/Guardian Signature _____

Date _____

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