



Alabama State Department of Education



Individualized Health Care Plan

Student Name:

School Year: _____

Asthma Individualized Healthcare Plan

SECTION I			
Student:			WT:
			HT:
Grade:	D.O.B	Any Known Allergies	
School:			
District:		Bus (check one) <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Bus #AM	Bus #PM
School Nurse:		Pager #	Cell #
Medication taken at home: (please list)			
Contacts			
Mother	Home #	Work #	Pager/Cell #
Father	Home #	Work #	Pager/Cell #
Guardian/Custodian	Home #	Work #	Pager/Cell #
Home Address		City #	Zip
Emergency Contact (Relationship)		Home #	Work #
Physician		Phone #	Fax#
Physician Address		City	Zip
Date	Special Notes		



Individualized Health Care Plan

Student Name: _____

School Year: _____

Asthma Individualized Healthcare Plan

SECTION II: Emergency Action Plan			
IF YOU SEE THIS...	Coughing, Wheezing Gaspng for Air	Prolonged Expiration Change in Color of Skin (Pale or Blue)	Tightness in Chest
DO THIS WHEN MEDICATION* AVAILABLE...			DO THIS WHEN MEDICATION NOT AVAILABLE...
*Med/Dose: _____ 1. Route: <input type="checkbox"/> Inhaler** <input type="checkbox"/> Nebulizer 2. Observe student for change in condition 3. Allow student to return to class if symptoms Relieved/Improved after medication.			Have student sit in calm, cool environment (if possible). Have student sit upright with hands on knees (arms straight). Encourage purse-lip breathing (slowly inhale through nose and exhale through pursed-lips).
If no change in symptoms after 15 minutes of medication: *Med/Dose: _____ 1. Route: <input type="checkbox"/> Inhaler** <input type="checkbox"/> Nebulizer 2. Call parent about student using medication x 2 3. Have student maintain sitting position 4. Limited physical activity.			
If no improvement in symptoms after second dose of medication and unable to contact parent after second dose is administered... 1. Call 9-1-1 (Continue trying emergency contacts) 2. Encourage slow deep breathing, rest 3. Have student maintain sitting position			
Student complains, is hunched over, has difficulty breathing, is unable to speak, uses neck/shoulder muscles to assist in breathing effort, lips and/or nail beds are blue in color 1. Call 9-1-1 2. Call parent/guardian 3. Rest, reassurance, calm slow deep breathing			
If student becomes unconscious... 1. Call 9-1-1 2. Call parent/emergency contact			If no improvement... 1. Call parent/emergency contact 2. Call 9-1-1

* ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER – SEE PAGE # 5

**Proper technique for using inhaler: Have student sit upright. Remove cap; hold inhaler upright. Shake well. Tilt head slightly back, and have student breath out. Position inhaler in or near mouth or use spacer. Have student take a deep breath; press down on inhaler while student is taking a breath. Count to 10 while student holds breath.

School Nurse Use Only

Medication	Expiration Date	Self-Carry?	Location of Medication



Individualized Health Care Plan

Student Name:

School Year:

Asthma Individualized Healthcare Plan

SECTION III

ASTHMA is a chronic lung disease, which is characterized by attacks of breathing difficulty. It is caused by spasms of the muscles in the walls of the air passages to the lungs. It is not contagious and tends to run in families. Asthma can be aggravated by allergy to pollen or dust, viral illness, cold, emotions, or exercise. There is no cure but asthma can be controlled with proper diagnosis and management. Treatment consists of avoiding known triggers, recognizing early symptoms, monitoring with a peak flow meter, and medication to reduce or prevent symptoms. Some children who are allergic to specific substances may benefit from desensitization shots.

AVOID EXPOSURE TO KNOWN TRIGGERS (please list):

MEDICATIONS AT SCHOOL:

- Albuterol Inhaler: [] W/SPACER [] W/O SPACER
On-Person [] YES [] NO
Authorized to Self-Administer [] YES [] NO
Nebulizer Treatment [] YES [] NO
Other:

POTENTIAL SIDE EFFECTS:

- [] Tremors - Rapid Heart Rate
[] Headache
[] Dizziness
[] Dry Mouth & Throat
[] Other: Type Here

MEDICATIONS AT HOME:

POTENTIAL SIDE EFFECTS:

CLASSROOM

- [] Avoid all Aerosols
[] Avoid cleaning substances with strong odors
[] Other (please specify)

Contact school nurse if student develops symptoms of acute asthma episode.

PHYSICAL EDUCATION:

- [] Student Requires Following Limitations:
[] Encourage Participation, but Do Not Force
[] Do Not Ignore Student's Symptoms.
[] Other:

Contact school nurse if student develops symptoms of acute asthma episode.

FIELD TRIPS:

- [] Student IS authorized to keep on person & self-administer inhaler:
[] Student will keep inhaler on person at all times.
[] Student will notify teacher/sponsor in the event inhaler is not relieving symptoms.
[] If student exhibits signs or symptoms of distress, teacher/sponsor will active 911, notify parent, & Admin
[] Student IS NOT authorized to keep on person & self-administer inhaler:
[] Nurse or Medication Assistant will accompany trip with medication & orders on person
[] Student will have ready access to Nurse or Medication Assistant for duration of trip
[] Parent will accompany trip

BUS TRANSPORTATION:

- [] Student IS authorized to keep on person & self-administer inhaler.
[] Student will keep inhaler on person at all times.
[] If student exhibits signs or symptoms of distress, after using inhaler, bus driver will activate 911, notify parent, and administration.
[] Other:
[] Student IS NOT authorized to keep inhaler on person & self-administer inhaler.
[] If student exhibits signs or symptoms of respiratory distress, bus driver will activate 911, notify parent, and administration.
[] Other:

EMERGENCY DRILLS & SCHOOL CRISIS EVENTS:

- [] In Crisis Event Follow School Safety Plan
[] School Nurse or designated personnel will deliver medications to designated location per crisis plan.
[] If authorized, student will keep inhaler on person Student requires mobility assistance [] YES [] NO
[] If YES describe plan: Type Here

BEFORE/AFTER SCHOOL EVENTS:

Notes and Comments:



Alabama State Department of Education



Individualized Health Care Plan

Student Name: _____

School Year: _____

Written Notes/Addendum to Plan of Care

Date	Notes	Nurses Signature

Signature of Parent or Guardian

Date

Signature of School Nurse

Date



Alabama State Department of Education



Individualized Health Care Plan

Student Name:

School Year:

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: _____ School: _____
 Date of Birth: ___/___/___ Age: _____ Grade: _____ Teacher: _____
 No known drug allergies---if drug allergies list: _____ Weight: _____ pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ Dosage: _____ Route: _____
 Frequency/Time(s) to be given: _____ Start Date: ___/___/___ Stop Date: ___/___/___

Reason for taking medication: _____
 Potential side effects/contraindications/adverse reactions: _____
 Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes No
 Is self-medication permitted and recommended? Yes No
 If "yes" I hereby affirm this student has been instructed
 On proper self-administration of the prescribe medication.
 Do you recommend this medication be kept "on person" by student? Yes No

Printed Name of Licensed Healthcare Provider: _____ Phone: () _____ - _____ Fax: _____ - _____

Signature of Licensed Healthcare Provider: _____ Date: _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ Date: ___/___/___ Phone: () _____ - _____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ Date: ___/___/___ Phone: () _____ - _____



Alabama State Department of Education

Individualized Health Care Plan

Student Name:

School Year

Communication of the Individualized Health Care Plan

SECTION IV

- Check this Box if Read Receipt is used to communicate Individualized Health Care Plan to staff.
* Nurse to attach Read Receipt document to this packet.
- Check this box if staff receives and signs below for Individualized Health Care Plan.

I have read and understand this student’s Individualized Healthcare Plan, and have printed a copy to be maintained in my confidential folder/binder of instructions for substitute teachers.

I have been given the opportunity to ask questions.

I understand my role in addressing this students medical needs.

I am aware the school nurse is available to help clarify any future concerns

Employee Name	Employee Signature	Position	Date