Asthma Individualized Health Plan

Student Name:	Graduation Year:
Parent/ Guardian Name(s):	Phone Number(s):

Asthma Triggers	Asthma Symptoms
_____ Exercise _____ Respiratory Infection/ Cold _____ Excitement / Stress/ Anxiety _____ Weather/ Environmental Irritants _____ Allergies (Please list):	_____ Wheezing _____ Dry Cough _____ Difficulty Breathing _____ Lips/Nails Blue _____ Chest Tightness _____ Other (Please list):

Treatment Plan

1) Call the school nurse (South Campus x4108 / North Campus x4208)
2) Have the student sit upright with shoulders relaxed.
3) Have the student administer any inhaler/medication order listed below by the physician.
4) If student symptoms are not resolving with medication, call parent/guardian. If parent/guardian are not immediately reached, call 911.

Parent/ Guardian Medication Consent

1) I authorize my student to self-carry their inhaler, if their physician agrees it is appropriate.
2) I have discussed with my student that they are to keep their inhaler in the front pocket of their backpack at all times. My student understands that they are not to share their medication.
3) I, hereby, give my permission for the school nurse, health room personnel, office staff or authorized school personnel to give the medication to my student according to the directions below should my student need assistance.
4) I, hereby, give the school nurse permission to contact the student's physician to discuss this action plan.
5) I further agree to hold the Arrowhead School District, and the above-identified person(s) harmless in any or all claims arising from the administration of this medication or the performance of this procedure at school.
6) I understand that this plan is valid for the duration of time that my student is enrolled at AHS. I agree to provide written notification to the school nurse at the termination of this request or when any changes are made in this care plan and/or medication.
7) If I cannot be reached by phone and my student does not respond to the medication listed below, 911 will be called to transport my student to the nearest hospital.

Parent/ Guardian Signature:	Date:

Physician Medication Orders

Inhalers for Asthma: May the student self-administer and keep the inhaler(s) under their control in such places as their backpack, purse, or pocket? _____ YES _____ NO

Name of Medication / Inhaler	Dose / Frequency	Time to be Administered or PRN	Duration
			Valid for duration of enrollment at AHS

Physician Authorization

Physician Name:	Physician Signature:	Date: