JOHNSON CITY SCHOOLS - HEALTH SERVICES
INDIVIDUAL HEALTH PLAN (IHP) – CONFIDENTIAL

Asthma

Student Information:

Name of Student: _____ Date of Birth: _____

School: _____ Grade: _____ Teacher: _____

Emergency Information:

Parent(s') Names: _____

Phone Number: _____ Phone Number: _____

Primary Care Physician: _____ Specialist: _____

Phone Number: _____ Phone Number: _____

Fax Number: _____ Fax Number: _____

In the event a parent/guardian cannot be reached:

Name: _____ Relation: _____ Phone Number: _____

Name: _____ Relation: _____ Phone Number: _____

Steps to take during an asthma episode:

- **NEVER** leave student alone. Remain calm. Encourage student to relax.
- Assist student with prescribed medication (as listed below).
- Student should respond to treatment in 15-20 minutes.
- Observe and record student's response to medication
- Observe student for adequate breathing

Signs and Symptoms of Asthmatic Illness:

- Tightness in chest
- Shortness of breath
- Audible wheeze or unusual breath sounds
- Anxious Appearance
- Prolonged coughing period

Seek Emergency Medical Help If:

- No improvement within 15-20 minutes after initial rescue medication used and parent(s) or emergency contact(s) cannot be reached.
- Struggles for breath, hunched over, sucks in chest and neck muscles with attempts to breathe.
- Difficulty walking and talking (can't finish sentences).
- Lips or fingernails turn blue or gray
- Decreasing or loss of consciousness.

Medical Information – To be completed by Physician's Office

Diagnosis: _____

Asthma Triggers/Environmental/Dietary Restrictions:_____

_____

Medication Orders: _____

Peak Flow Meter Orders: _____

Hand Held Nebulizer Orders: _____

(Hand Held Nebulizer will be kept in Clinic)

Please check one: ❑ Student's inhaler to be kept in clinic.

❑ Student can keep inhaler on person and is able to use inhaler independently. **(Authorization may be revoked if used inappropriately at any point during the school year)**

Physician's Signature: _____ ***Date:*** _____

I, the parent or guardian of the above student, request that this Individual Health Plan (IHP) be administered to my child. I understand that it is my responsibility to provide the school with the necessary supplies and medication and will notify the school if there is any change to my child's health status. I agree to provide a new consent for any changes in doctor's orders and authorize the school nurse. To communicate with the physician when necessary. I understand that this information will be shared with the appropriate members of the educational team.

Parent's/Guardian's Signature: _____ Date: _____

Reviewed by: _____ Date: _____