OAK HARBOR Public Schools

ASTHMA
Individual Health Plan

Student Name	DOB
School	Grade
School Year	Advisor

MEDICAL INFORMATION

Asthma History & Current Medication	
Triggers	
Special Precautions	

MEDICATION ORDERS - Must be completed by a Licensed Health Care Professional

Medication Name: _____ Dose: _____ When: _____

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If PRN, Specify time between doses: _____

It is medically necessary for this student to carry an inhaler on his/her person during school hours ☐ Yes ☐ No

Student may self-administer Inhaler ☐ Yes ☐ No Student has demonstrated Inhaler use to LHP ☐ Yes ☐ No

Provider's Signature: _____ ☐ Signature on file Date: _____

Provider's Name: _____ Provider's Phone: _____

EMERGENCY INTERVENTION

(Not all students will experience all symptoms during an asthma attack)

Please check all that apply	What to do
☐ Excessive Coughing	Accompany student to health room **(do not send alone)**
☐ Wheezing	Give medication as prescribed by IHP
☐ Shortness of Breath	Keep student sitting up and reassure student
☐ Chest Tightness	Encourage to relax and take deep slow breaths
☐ Nostrils Flaring	Encourage student to drink warm water
☐ Shoulders Hunched Over	Stay with student until improvement noted
☐ Anxious or Scared	Contact School Nurse
	Contact parent if no improvement after 15-20 minutes

Severe Symptoms	Immediate Response
Lips of nail beds turning gray or blue (students with light complexion)	**Call 911**
Paling of lips or nail beds (students with dark complexions)	**Notify Parent**
Grunting	**Notify School Nurse**
Inability to speak in complete sentences without taking a breath	**Notify School Principal**
Severe restlessness	
Decreasing or loss of consciousness	**Do not leave the student unattended**

Student Name	Grade

Parent/Guardian Information

I give Health Services Staff permission to communicate with the Physicians office about this medication ☐ Yes ☐ No
I request and authorize my child to carry and/or self administer their medication. ☐ Yes ☐ No

Permission to possess a metered dose inhaler and Epinephrine Auto-Injector may be revoked by the principal or school nurse if it is determined that your child is not safely and effectively able to self administer.

Release of liability for self-carry and self-administration of inhalers and EpiPens: I take responsibility for my child's adherence to the dosing schedule; OHPS will not monitor self administration.

_____ **Parent initial required for student to self carry and self administer inhalers and EpiPens.**

Parent/Guardian	Home Phone
Work Phone	Cell Phone
Parent/Guardian	Home Phone
Work Phone	Cell Phone

SIGNATURES

Parent/Guardian	☐ Signature on File	Date
School Nurse	☐ Signature on File	Date

A copy of this plan will be kept in the school office and copies will be given to all appropriate staff.