Student Photo

HUDSON PUBLIC SCHOOLS
Hudson, MA 01749
School Year _____ to _____

# INDIVIDUALIZED HEALTH CARE PLAN – ASTHMA

Student _____ DOB_____
Teacher_____Grade/Team_____Parent/Guardian_____
Phone (H)_____ Phone (W)_____Phone (Cell)_____
Emergency Phone Contact_____
Name Relationship Phone (home,work,cell)

**EMERGENCY PLAN**

**Emergency action is necessary when the student has symptoms such as_____,**
**_____,or has peak flow reading of:_____.**

**STEPS TO TAKE DURING AN ASTHMA EPISODE (Refer to Asthma Action Plan if available):**

1. Check peak flow if available
2. Give medications as listed below. Student should respond to treatment in _____minutes.
3. Contact parent if_____
4. Recheck peak flow if available
5. **Seek emergency medical care if the student has any of the following:**
   - Coughs constantly
   - No improvement after____minutes after initial treatment and parent/guardian cannot be reached
   - Peak Flow of_____
   - Difficulty breathing
   - Trouble walking or talking
   - Lips or fingernails are gray or blue

**PRN/Rescue Asthma Medication** **Location of medications:_____**

□ Albuterol (Proair) Inhaler Dose:_____ Frequency:_____ □Daily□PRN
□ Albuterol Nebulizer Dose:_____ Frequency: _____ □Daily□PRN
Comments:_____
_____

**Self-Administration of Asthma Medications**

Regulation 105 CMR 210.006 allows the self-administration of medication by students provided that the student, school nurse, and parent or guardian enters into an agreement specifying under which conditions prescription medication may be self-administered. Further, written authorization from a student's parent or guardian that allows self-administration of prescription medication must be provided.

| | | | | | | |
|---|---|---|---|---|---|---|
| **Parent Authorization for** | **Self- Administration** | **YES** | **NO** | **Self-carry** | **YES** | **NO** |
| **School Nurse approval for:** | **Self-Administration** | **YES** | **NO** | **Self-carry** | **YES** | **NO** |

If applicable, ATTACH SIGNED SELF-ADMINSTRATION CONTRACT

_____ _____
**Parent/Guardian Signature / Date** **School Nurse Signature / Date**

***See reverse for more instructions***

DAILY ASTHMA MANAGEMENT PLAN for_____
Name of Student

- Identify the triggers which may start an asthma episode (Check each that applies)

  - ☐ Exercise
  - ☐ Seasonal weather changes-time of year
  - ☐ Chalk dust/ dust
  - ☐ Change in temperature
  - ☐ Pollen
  - ☐ Respiratory infections, colds
  - ☐ Carpets in the Room
  - ☐ Animals (types)_____
  - ☐ Mold
  - ☐ Other _____

- Identify typical symptoms of an asthma episode:

  - ☐ Wheezing
  - ☐ Coughing
  - ☐ Difficulty breathing
  - ☐ Shortness of Breath
  - ☐ Other (describe)_____

Daily Medication Plan

| Name | Amount | When to use |
|---|---|---|
| 1._____ | | |
| 2._____ | | |
| 3._____ | | |

Comments/Special Instructions:
_____
_____
_____

Date Completed:_____