**CMCSS ASTHMA INDIVIDUAL HEALTH CARE PLAN**

*Effective for school year 20___ - 20___ only and MUST be renewed each school year*

**This page is to be completed by PARENT/GUARDIAN**

**Student's Name:** _____ **Age:** _____

**List Known Allergies:** _____

**Teacher:** _____ **School:** _____ **Grade:** _____

***Please Note*** **: It is the Parent's/Guardian's responsibility to keep ALL contact/emergency information up-to-date**

Parent(s)/Guardian(s) Name and **BEST** Emergency Contact Information:

| | |
|---|---|
| Name: _____ | Name: _____ |
| phone #: (_____)_____(Hm/Wk/Cell) | phone #: (_____)_____(Hm/Wk/Cell) |

**Signs and Symptoms that may occur during an asthma attack (check all that apply):**

____ Tightness in chest ____ Shortness of breath ____ Coughing

____ Increased respiratory rate ____ Fear/Anxiety ____ Wheezing

____ Unable to speak without taking a breath ____ Nasal flaring ____ Agitation

____ Other _____

**Known triggers that may bring on an asthma episode:** _____

_____

**List any environmental measures/pre-medications/dietary restrictions needed to PREVENT an asthma episode:**

_____

**Emergency Care Plan (check all that apply) and Emergency medication(s):**

___ Talk calmly to student ___ Monitor and record lungs sounds until improved

___ Position student comfortably ___ Monitor and record vital signs until improved

___ Encourage deep, slow breathing ___ Assist in administration of emergency medication

___ Notify School Nurse if _____

___ Notify Parent/Guardian if _____

| Medication | Dose | Route | When to Use | How soon can it be repeated? |
|---|---|---|---|---|
| **(HEA-F062 Authorization for Medication to be Taken During School Hours must be completed for each medication)** | | | | |
| | | | | |
| | | | | |
| ***911/EMS will be called if student shows no improvement and parent/guardian cannot be reached*** | | | | |

I, as parent/guardian, **DO ___ DO NOT ___** request that my child, named above, be permitted to carry and self-administer emergency medication, and/or equipment, **as ordered by healthcare provider.**

The secure location (on student's person) where emergency medication will be kept:

**backpack ___ sports bag ___ purse ___ binder ___ OTHER: _____**

I, as parent/guardian, **DO ___ DO NOT ___** require my child's inhaler usage to be monitored by the school nurse.

I, as parent/guardian acknowledge that the school and its employees shall incur no liability as a result of any injury sustained by my child, or any other person, as a result of possession or self-administration of the emergency medication. I shall also indemnify, and hold harmless, the school and its employees against any claim relating to the possession or self-administration of the emergency medication. I also understand that the school may suspend or revoke my child's possession and self-administration privileges if he/she misuses the emergency medication or makes it available for usage by another person.

| | | |
|---|---|---|
| **Parent / Guardian Signature:** | _____ | **DATE:** _____ |
| **School Nurse Signature:** | _____ | **DATE:** _____ |
| **District RN Signature:** | _____ | **DATE:** _____ |

**(HEA-F062 Authorization for Medication to be Taken During School Hours must be completed for each medication)**