



Alabama State Department of Education



Individualized Health Care Plan

Student Name: Type Here

School Year: Type Here

Asthma Individualized Healthcare Plan

SECTION I			
Student:			WT:
			HT:
Grade:	D.O.B	Any Known Allergies	
School:			
District:		Bus (check one) <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Bus #AM	Bus #PM
School Nurse:	Pager #	Cell #	
Medication taken at home: (please list)			
Contacts			
Mother	Home #	Work #	Pager/Cell #
Father	Home #	Work #	Pager/Cell #
Guardian/Custodian	Home #	Work #	Pager/Cell #
Home Address		City #	Zip
Emergency Contact (Relationship)		Home #	Work #
Physician		Phone #	Fax#
Physician Address		City	Zip
Date	Special Notes		



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SECTION II: Emergency Action Plan			
IF YOU SEE THIS...	Coughing, Wheezing Gaspng for Air	Prolonged Expiration Change in Color of Skin (Pale or Blue)	Tightness in Chest
DO THIS WHEN MEDICATION* AVAILABLE...		DO THIS WHEN MEDICATION <u>NOT</u> AVAILABLE...	
*Med/Dose: <u>Type Here</u> 1. Route: <input type="checkbox"/> Inhaler** <input type="checkbox"/> Nebulizer 2. Observe student for change in condition 3. Allow student to return to class if symptoms Relieved/Improved after medication.		Have student sit in calm, cool environment (if possible). Have student sit upright with hands on knees (arms straight).	
If no change in symptoms after 15 minutes of medication: *Med/Dose: <u>Type Here</u> 1. Route: <input type="checkbox"/> Inhaler** <input type="checkbox"/> Nebulizer 2. Call parent about student using medication x 2 3. Have student maintain sitting position 4. Limited physical activity.		Encourage purse-lip breathing (slowly inhale through nose and exhale through pursed-lips).	
If no improvement in symptoms after second dose of medication and unable to contact parent after second dose is administered... 1. Call 9-1-1 (Continue trying emergency contacts) 2. Encourage slow deep breathing, rest 3. Have student maintain sitting position			
Student complains, is hunched over, has difficulty breathing, is unable to speak, uses neck/shoulder muscles to assist in breathing effort, lips and/or nail beds are blue in color 1. Call 9-1-1 2. Call parent/guardian 3. Rest, reassurance, calm slow deep breathing			
If student becomes unconscious... 1. Call 9-1-1 2. Call parent/emergency contact		If no improvement... 1. Call parent/emergency contact 2. Call 9-1-1	

* ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER - SEE PAGE # 5

**Proper technique for using inhaler: Have student sit upright. Remove cap; hold inhaler upright. Shake well. Tilt head slightly back, and have student breath out. Position inhaler in or near mouth or use spacer. Have student take a deep breath; press down on inhaler while student is taking a breath. Count to 10 while student holds breath.

School Nurse Use Only

Medication	Expiration Date	Self-Carry?	Location of Medication



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SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: _____ **School:** _____
Date of Birth: ___/___/___ **Age:** _____ **Grade:** _____ **Teacher:** _____
 No known drug allergies---if drug allergies list: _____ **Weight:** _____ pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____ **Route:** _____
Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____
 Potential side effects/contraindications/adverse reactions: _____
 Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes No
 Is self-medication permitted and recommended? Yes No
 If "yes" I hereby affirm this student has been instructed
 On proper self-administration of the prescribe medication.
 Do you recommend this medication be kept "on person" by student? Yes No

Printed Name of Licensed Healthcare Provider: _____ **Phone:** () _____ - _____ **Fax:** _____ - _____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** () _____ - _____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ___/___/___ **Phone:** () _____ - _____

