

**INDIVIDUAL HEALTH PLAN / EMERGENCY CARE PLAN FOR STUDENT WITH  
ASTHMA/REACTIVE AIRWAY DISEASE (RAD)**

TO BE RENEWED EACH SCHOOL YEAR

(If you need assistance completing this form, contact the Licensed School Nurse.)

Student Name \_\_\_\_\_ Birth Date \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Teacher \_\_\_\_\_ School Year \_\_\_\_\_

**1. My child still has Asthma/RAD:**

**YES Complete form, sign & date back, and return to your child’s school.**

**NO (If “No” is checked, do not fill out the remainder of the form, but sign and return.)**

**2. Where does your child receive his/her Asthma/RAD care?**

Health Care Provider/Clinic \_\_\_\_\_ Phone Number: \_\_\_\_\_

**3. How many times has your child been treated in the emergency department or hospitalized for Asthma/RAD in the past year? \_\_\_\_\_**

**4. What triggers your child’s Asthma/RAD attacks?**

exercise weather changes emotional stress

upper respiratory infections smoke

allergies (please list): \_\_\_\_\_

**5. What are your child’s usual signs and symptoms of an Asthma/RAD attack? (Please check all that apply)**

constant/frequent cough wheezing

difficulty breathing/talking chest tightness

other: \_\_\_\_\_

**6. Does your child recognize these signs and symptoms? YES NO**

**7. What does your child do at home to relieve signs and symptoms of an Asthma/RAD attack?**

(Please check all that apply)

breathing exercises drinks liquid

rests medication

**8. Please list medication taken daily at home for Asthma/RAD: Oral: \_\_\_\_\_ Inhaled: \_\_\_\_\_**

**9. Will your child have medication at school? YES NO**

If Yes, where will the mediation be kept in the Health Office with the student.

**10. Emergency Contacts (list in order of who to call first)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

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**SCHOOL ACTION/EMERGENCY PLAN**

1. Calm and reassure the student.
2. Give inhaler/nebulizer if available as authorized by parent/guardian and prescribed by the health care provider.
3. Have the student in sitting position, encourage slow breathing: in through nose and out through pursed lips.
4. Offer sips of water.
5. Call the parent/guardian if the student’s breathing has not improved or if medication does not relieve symptoms in 15 minutes.

**Call 911 if symptoms are not improving with ANY of the following signs or symptoms observed: (Notify office and parent when 911 is called.)**

**-Breathing is hard and fast  
-Ribs show**

**-Student cannot talk or walk  
-Nose opens wide to breathe**

**SCHOOL MANAGEMENT PLAN / PARENT/GUARDIAN AUTHORIZATION**

Please select one

No inhaler/nebulizer at school.

- Call the parent if attack occurs.
- Follow the school emergency plan.

Student needs help with Asthma/RAD signs and symptoms.

- May use inhaler/nebulizer with supervision. A **Medication Consent** form must be completed and signed by the health care provider and parent/guardian.
- **The inhaler is properly labeled for the student.**
- Follow the school emergency plan.

Student can **self-manage** Asthma/RAD signs and symptoms, and may independently carry and use the inhaler.  
*(Not recommended for elementary students)*

- A **Medication Consent** form must be completed and signed by the health care provider and parent/guardian indicating the student can self manage.
- **The inhaler is properly labeled for the student.**
- Students who self-manage their Asthma/RAD will NOT be monitored by school personnel on a daily basis
- The health office staff will assess the student's knowledge and skills to safely possess the inhaler in a school setting. If non-compliance or a change in status occurs, the Licensed School Nurse will contact parent/guardian to discuss a new agreement.

1. I understand that this information may be shared with all school staff who work directly with my child.
2. I will contact the Licensed School Nurse/designee if a change in the current plan is indicated.
3. I authorize the Licensed School Nurse/designee to exchange information with my child's health care provider related to his/her Asthma/RAD plan.
4. Field trips - I give permission for a teacher/school personnel to assist with the administration of the inhaler on a field trip.
5. **I understand if my child rides the school bus and/or participates in before or after school activities, it is my responsibility to inform the staff/bus company of my child's health plan.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Licensed School Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_