# Asthma/ Reactive Airway Disease

School Year: _____ Grade: _____

## INDIVIDUAL HEALTH PLAN

Student Name: _____ DOB: _____
Parent/Guardian: _____ Phone: _____
Emergency Contact: _____ Phone: _____

Severity of Classification:
- ☐ Mild Intermittent
- ☐ Mild Persistent
- ☐ Moderate Persistent
- ☐ Severe Persistent

Triggers:
- ☐ Illness ☐ Exercise ☐ Animals (list) _____
- ☐ Dust ☐ Smoke ☐ Weather / Change of Season
- ☐ Smells/fumes from cleaners, hairsprays, perfume, colognes, etc… (may require 504 plan)
- ☐ Other: _____

*School Nutrition Modification Evaluation Form must be completed by prescribing physicians for ALL dietary modifications.*

☐ Daily medication / treatment at school: _____
☐ Required exercise modifications: _____

**MILD DISTRESS >>>>>>>>>> ACTION >>>>>>>>>>> Administer Medication – MD – specify in box below.**

☐ Wheezing ☐ Coughing ☐ Shortness of Breath ☐ Other: _____

*Students cannot wait until the end of class for treatment. Students even in minimal distress should NEVER leave the classroom alone.*

Medication: MD- Please specify
☐ Antihistamine _____

**SEVERE DISTRESS >>>>>>>>>> Call 911/EMS**

☐ Severe difficulty breathing ☐ Coughing without recover

☐ Other _____

- ✓ Call the school nurse for immediate assistance.
- ✓ Give medication (if prescribed)
- ✓ Contact parent/guardian immediately

Location of medication: ☐ Health Unit ☐ Must be with students at all times, either on the person or with an accompanying adult.

Administration of medication: ☐ School nurse or trained unlicensed school personnel ☐ Self administration with adult supervision

☐ Independent Self Administration – It is my professional opinion that this student is able to carry above prescribed medication with them at all times – during the school day, on field trips, and while participating in before or after school clubs/events/athletics. He/she has been instructed on the indication for medication usage and the method of administration.

*Please note: The school nurse does not always attend field trips or after school events/clubs/athletics. For this reason non-medical, unlicensed school staff members are trained to administer medication. Student authorized for independent self-administration of medication are not monitored by school staff, however school staff are available for emergency response during all school sponsored activities.*

Prescription medication or treatment daily at home for this condition: _____

During a field trip, scheduled daily medication:
- ☐ requires a trained staff member to administer medication
- ☐ is authorized to carry and self-administer medication

X _____ _____ _____
Physician or Authorized Healthcare Provider Signature | Telephone Number | Date Signed

I am the parent/guardian of the above named student and give consent and permission for the information on this form to be shared with teachers, principals, and other staff members that have direct contact with my child for the current school year. I understand that a trained school staff member may administer prescribed medication and/or assist my child to comply with his/her physician's prescribed medications or treatments if needed. If my child's physician gives authorization for my child to carry and self-administer his/her medication, I consent and understand that medication independently self-administered is not monitored by staff. I agree to provide the necessary prescribed medication or treatment supplies and agree to notify the school nurse immediately of any changes.

The school health staff shall contact the student's parent/guardian to discuss any concerns regarding the student's care which might require medical follow-up and/or shall contact the health care provider to obtain current information verbally when necessary to manage the student's condition at school. I understand that the Rockcastle County Board of Education Medication Policy and Procedures are readily available for me to read.

I hereby agree to release and hold staff members free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment described by me or prescribed by my child's physician. I have read and understand this consent. I sign it voluntarily and with full knowledge of its significance.

X _____ _____
Parent/Guardian Signature | Date Signed