Individual Health Plan (IHP) – Asthma **Date of IHP**______________________________

Student Name______________________________ID #____________HR_________Team______________________
Grade____________Teacher_____________Bus #__________AM______PM_____Car Rider_______Other_______

Additional health concerns:____
____

Has your child been hospitalized for an asthma attack?____________If yes, please describe incident and length of stay____

Identify what" triggers" an asthma episode (check all that apply)

☐ Exercise	☐ Illness	☐ Molds
☐ Respiratory Infections	☐ Animals/fur/hair	☐ Food
☐ Changes in temperature	☐ Dust	☐ Other
☐ Strong odors or perfumes	☐ Pollen	

Can your child identify his/her early signs and symptoms of an asthma episode?___________

Medications to be taken prior to Physical Education?
_________YES _________NO Physical Education day(s)_________________Time___________

Medication to be taken prior to Recess?
_________YES __________NO Recess time_____________

Does your child use Peak Flow Monitoring?_________YES __________NO **If yes,**
Personal best peak flow number________________ Yellow Zone_______Red Zone___________
Monitoring Times: _____________ _____________ _____________

Does your child require assistance using inhaler?_____________________
Does your child require assistance to use peak flow?_________________
Does your child require use of a nebulizer?__________________________
Does your child have a "self carry" order for inhaler?_______ **(MCS-202)Must be documented on MD order**

Medications to be taken at school.

(MCS-202) Must be completed and signed by Physician for each medication

Name of Medication	Indication for usage	MCS-202 attached?
		☐ Yes
		☐ Yes
		☐ Yes

Parent/Guardian Name___________________________Phone Number(s)_____________________________________

Parent Signature________________________________Date____________

CLINIC USE ONLY: TO BE FILLED OUT BY CLINIC RN
Physician orders Rec_________Medication_________Date Rec_________Location(s)_____________EXP_________
Physician orders Rec_________Medication_________Date Rec_________Location(s)_____________EXP_________

Transportation notified/copy IHP	Date:	Initials:
Classroom teacher Notification	Date:	Initials: