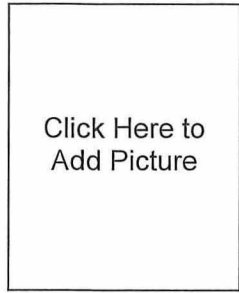


INDIVIDUALIZED HEALTH CARE PLAN

Livonia Public Schools

Confidential

Name: _____
 Health Concern: **ASTHMA**
 Date of Birth: _____ Student ID: _____
 Case Manager: _____ Ext: _____



- Asthma Triggers:
- | | | | |
|---|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> cats | <input type="checkbox"/> dogs | <input type="checkbox"/> molds | <input type="checkbox"/> pollen |
| <input type="checkbox"/> smoke | <input type="checkbox"/> fumes | <input type="checkbox"/> cold air | <input type="checkbox"/> dust / dust mites |
| <input type="checkbox"/> respiratory infections | <input type="checkbox"/> humidity | <input type="checkbox"/> | <input type="checkbox"/> |

Usual Asthma Symptoms: _____

GREEN ZONE	<u>DOING WELL</u>	Peak flow from _____ to _____	Use these daily controller medicines:		
	<ul style="list-style-type: none"> ⊕ Breathing is good ⊕ No cough or wheeze ⊕ Sleep through the night ⊕ Can go to school 		Medication / Route	How Much	How Often / When

YELLOW ZONE	<u>SLOW DOWN</u>	Peak flow from _____ to _____	Continue with Green Zone medication and add:		
	<ul style="list-style-type: none"> ⊕ First signs of a cold ⊕ Mild wheeze or cough ⊕ Tight chest ⊕ Wheezing, coughing or trouble breathing at night 		Medication / Route	How Much	How Often / When

If symptoms do not improve, contact parent / guardian

RED ZONE	<u>GET HELP</u>	Peak flow from _____ to _____	Take these medicines and call 9-911 now:		
	<ul style="list-style-type: none"> ⊕ Medicine is not helping ⊕ Chest sucking in ⊕ Breathing is hard and fast ⊕ Nostrils open wide ⊕ Ribs showing ⊕ Trouble talking or walking ⊕ Lips or fingernails blue / purple 		Medication / Route	How Much	How Often / When

If symptoms do not improve, call 9-911 from a landline now

CONTACTS

_____	_____	_____	_____
Name	Relationship	Phone #1	Phone #2
_____	_____	_____	_____
Name	Relationship	Phone #1	Phone #2

The following individuals have reviewed this Health Care Plan and support its implementation.

Parent / Guardian Signature _____ Date _____ Administrator Signature _____ Date _____ Doctor Signature (required) _____ Date _____