Lake Washington School District

LWSD Health Services

# ASTHMA - Individual Health Plan (IHP)

**Student Name:** _____ **DOB:** _____

School: _____ Year: _____

Grade: _____ Student #: _____

Teacher: _____

Transportation: ☐ Walker ☐ Bus ☐ Parent/Guardian ☐ Student Driver ☐ Other: _____

## EMERGENCY CARE PLAN

| Moderate Symptoms | Immediate Response |
|---|---|
| • Excessive coughing<br>• Wheezing<br>• Shortness of breath<br>• Rapid breathing<br>• Chest tightness<br>• Nostrils flaring<br>• Shoulders hunched over<br>• Anxious or scared<br><br>Some students may not be able to communicate their symptoms clearly because of their age or developmental challenges. | **If student is experiencing any moderate symptoms inhaler must be given immediately as prescribed.**<br><br>1. Keep student in their current location, maintain adult supervision<br><br>2. **LOCATE*** student's inhaler (see below)<br>• Self-carry: check backpack or on person<br>• Health Room: request staff to bring inhaler to student's location<br><br>3. Support student to use medication as prescribed, inhaling slowly and fully<br>• Document time medication was administered<br><br>4. Stay with student and provide comfort measures. Student should remain sitting and take slow deep breaths<br><br>5. If symptoms worsen or are not improving after medication has been given as prescribed, CALL 911, then contact School Nurse and parent/guardian |
| **SEVERE SYMPTOMS** | **IMMEDIATE RESPONSE** |
| • Color change on tongue, lips, around the eyes, fingertips or nail beds. Color change may appear gray or white on darker skin tones and blue on lighter skin tones<br><br>• Grunting/gasping or working hard to breathe<br><br>• Inability to speak in complete sentences without taking a breath<br><br>• Severe restlessness<br><br>• Decreasing or loss of consciousness | **Call 911 and request AED to student location if student is experiencing any severe symptoms.**<br><br>• If not already given, immediately give inhaler as prescribed<br><br>• If the student is unresponsive, not breathing, and/or has no pulse, start CPR, turn on AED and follow prompts<br><br>• Students who have both asthma and anaphylaxis are at increased risk for severe reactions, requiring aggressive and prompt treatment. Epinephrine may be indicated. Follow orders. |

## Medications/Interventions:

Allergies: ☐ No ☐ Yes If yes, list: _____

***INHALER LOCATION:** ☐ **Health Room** ☐ **Self-Carry Location:** _____ ☐ **Other:** _____

Additional Medication at School: ☐ No ☐ Yes If yes, list: _____

• Location of Additional Medication: ☐ Health Room ☐ Self-Carry Location: _____ ☐ Other: _____

Medication at Home: ☐ No ☐ Yes If yes, list: _____

Preferred Hospital: _____

## Asthma History:

**Date of Asthma Diagnosis:** _____

In the past year, has your student received emergency care due to asthma or respiratory distress?

☐ No ☐ Yes If yes, explain: _____

**Asthma Triggers:** ☐ None known ☐ Animals ☐ Cold air ☐ Exercise ☐ Pollens ☐ Smoke, Odors ☐ Illness

☐ Other triggers: _____

**Usual Symptoms:** ☐ Cough ☐ Wheeze ☐ Shortness of breath ☐ Chest tightness ☐ Asking to use inhaler

☐ Other: _____

## Additional Asthma Information (optional):

## Supplementary Information:

**Before signing, parent/guardian should review and complete this IHP in its entirety. A new IHP must be submitted each school year. The School Nurse must be notified if any changes are needed to this plan during the school year.**

- LWSD schools do not staff a nurse on site during all school hours.
- Teacher will communicate medical concerns to their substitutes by placing a copy of each health plan in the substitute file.
- School Nurse will ensure a copy of the health plan is kept in the health room, available for field trips, and in Skyward for staff.
- According to Washington State Law (RCW 28A.210.320 & RCW 28A.210.370), the attendance of every child shall be conditioned upon the presentation before or on the child's first day of attendance, an annual individual health plan, a medication of treatment order addressing any life-threatening health condition that the child has that may require medical services to be performed at school, and the provision for storage of medical equipment and medication provided by the parent. Once such a health plan, order, and medication/supplies have been presented if applicable, the child shall be allowed to attend school.

## Parents / Guardians:

| Name | Relationship | Phone Number | Other Number | Address |
|---|---|---|---|---|
| | | | | |
| | | | | |

**Additional Contact (optional):**

| | | | | |
|---|---|---|---|---|
| | | | | |

Parent Name (Print): _____

Parent Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

Confidential Information - shred prior to discard