

**CHAMBERSBURG AREA SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
ASTHMA: INDIVIDUALIZED CARE PLAN**

Student's Name _____ Date ____ / ____ / ____

Parent/Guardian _____ Home Phone _____

Address _____ Work Phone _____

Physician Treating Asthma _____ Phone # _____

1. Briefly describe what causes the child's asthma symptoms.

2. Does he or she do breathing exercises that are helpful in managing the asthma? If so, please describe. _____

3. In which sports can the child fully participate?

4. Does exercise induce episodes of asthma? If so, please list the exercises.

5. Do certain weather conditions affect your child's asthma? If so, please list them.

6. List the medications taken routinely, the dose, how often taken, when and under what circumstances additional doses should be given. _____

7. Does your child suffer any side effects to these medications? If so, please describe them. _____

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8. Does your child understand asthma and what he or she should do to manage it?
___Yes ___No

9. How do you want the school to treat an episode of asthma if it should occur?: _____

10. Approximately how often does your child have acute episodes? _____

11. If your child does not respond to medication, what action do you advise school personnel to take? _____

12. Does your child carry an inhaler on the bus? ___Yes ___No

Comments: _____

Signature of Parent/Guardian

Date

Asthma: Individualized Care Plan 03/01, 08/02, 04/05

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