Asthma Individual Health Plan

Name		School	
Birthdate		Grade	
Parent(s)		Phone	
Parent Email		Phone	

Health History

When was your child diagnosed?	
Has your child been hospitalized for asthma? When? Most recent?	
How often has your child been seen for asthma in the emergency room?	
Does your child have allergies? Please list.	
Other pertinent information:	

Asthma Signs and Symptoms (check those that apply for your child)

☐ Wheezing	☐ Chest Tightness	☐ Mucus
☐ Cough	☐ Shortness of Breath	☐ Other

Asthma Triggers (check those that apply)

☐ Illness	☐ Animals	☐ Smells	☐ Foods
☐ Exercise	☐ Smoke	☐ Cold Weather	☐ Emotions
☐ Allergies	☐ Dust	☐ Hot Weather	☐ Other

Medications (check those available at school)

Medication Name	Dose / Route	Frequency / Time of Day	At school?
			☐
			☐
			☐
			☐
			☐

Asthma Individual Health Plan

Permission for student to self-carry rescue inhaler.

My child has permission to carry and administer his/her own inhaler: ☐ yes

Needed Accommodations at School (check those that apply)

☐ Modified Gym Class	
☐ Modified Recess	
☐ No Animal Exposure	
☐ Food Avoidance	
☐ Other	

Asthma Action Plan (AAP)

* If there is an AAP please provide to health office

If your child has increased asthma symptoms at school, we will do the following:

- Check peak flow if available and child is not in acute distress
- Administer rescue medication according to medical order
- Offer water
- Contact parent/guardian to report
- Recheck Peak flow meter after 15-20 minutes to monitor progress
- Call 911 if medication is not working and symptoms are worsening; if child is having difficulty with breathing, walking or talking; if there are color changes such as blueness

Is there anything else that we should know about this student?

Hospital preference:

Parent/Guardian Signature:

I give permission for my child to receive prescribed medication at school. I authorize reciprocal release of information between Wayzata Public Schools' Health Services personnel and the prescribing professional.

	Date

Medical Provider Signature:

Medical Provider Name:	Medical Provider Phone:
Medical Provider Signature:	Date