INDIVIDUALIZED ASTHMA HEALTH PLAN

SCHOOL YEAR_____________ CAMPUS______________

NAME: DOB: Regular IHCP ❑ 504 IHCP ❑

ASTHMA TRIGGERS:

Inhaler use demonstrated to School Nurse: Yes____ No ____ Needs technique re-enforcement: Yes_____ No_____

GREEN - MAINTENANCE - Breathing is good - No coughing or wheezing - Can work & play **Peak Flow Number** **______ to______**	**Medication & Dose:** **When to give:**
YELLOW – CAUTION - Coughing - Wheezing - Tight chest **Peak Flow Number** **______ to ______**	**Medication & Dose:** **When to give:**
RED - DANGER - Medicine is not helping - Breathing is hard & fast - Nose opens wide - Can't talk well or walk **Peak Flow Number** **______to ______**	**Medication & Dose:** **When to give:** **DON'T HESITATE TO CALL 911**

Health Action Plan:

MEDICATION IS LOCATED AT___________________; IF STUDENT IS IN DISTRESS DO NOT SEND ALONE

Other health concerns:

Additional Medications:	**Dose/Time:**

Dietary concerns/restrictions:

Parent Signature:	**Date**:
M.D. Signature (**or Med. Authorization form**):	**Date**:

CONTACT INFORMATION

Parent/Guardian:	**Home phone:**
1.________________________	Work: Cell:____________
2.________________________	Work: Cell:____________

Primary Care Physician:	**Teacher**:
Emergency contact:	**Phone:**

Copies: ◻ Parent ◻ Teacher ___________________ ◻ PE ◻ Library ◻ Music ◻ Transportation ◻ Nurse ◻ Cafeteria

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