INDIVIDUALIZED HEALTHCARE PLAN FOR STUDENTS WITH ASTHMA
2024-2025 SCHOOL YEAR

To be completed by the Parent:

School: _____ Grade: _____

Students Name: _____ Age: _____

Student needs to avoid: _____

Reaction(s) student has: _____

Self-Carry permission from a physician: ☐ **NO** ☐ **YES;** Student will carry inhaler (where): _____

If yes, (1) the prescription medicine has been prescribed for that student as indicated by the prescription label on the medicine; (2) the student has demonstrated to the student's physician or other licensed health care provider and the school nurse, if available, the skill level necessary to self-administer the prescription medication, including the use of any device required to administer the medication; and (3) the self-administration is done in compliance with the prescription or written instructions from the student's physician or other licensed health care provider. In addition, as the parent, I am providing written authorization for my student to self-administer the prescription medicine while on the property or at a school-related event or activity. I understand that such self-administration must be done in compliance with the prescription or written instruction of the student's physician. Additionally, I have provided a written statement from my student's physician or other licensed health care provider, signed by the physician or provider that states:

1. That the student has asthma and can self-administer the prescription medicine.
2. The name and purpose of the medicine.
3. The prescribed dosage of the medicine.
4. The times at which or circumstances under which the medicine may be administered; and
5. The period for which the medicine is prescribed

Medication and inhaler at the school location for medication will be stored: **(required):** _____

Parent/Guardian Signature: _____ Date: _____

EMERGENCY CONTACTS	OTHER EMERGENCY CONTACTS
PARENT/GUARDIAN: _____	NAME: _____
PHONE: _____	PHONE: _____
DOCTOR: _____	NAME: _____
PHONE: _____	PHONE: _____

_____ (Student's Name) has asthma as mentioned in the Individualized Healthcare Plan from the physician. I have provided the school with the physician's medication permission and instructions. I am requesting these instructions be carried out by the school. I have instructed my child about his/her asthma and how to avoid exposure to the triggers, care to take if exposure occurs, and tell an adult immediately if they are having a reaction. I will provide the medication with a proper pharmacy label and be aware of the expiration date to replace the medication. I hereby request the medication specified by the physician be given to the above-named student, and it may be administered by medical or non-medical personnel. I understand 911 may be called if symptoms worsen.

Such agreement by the school is adequate consideration of my agreements contained herein. In consideration for the school agreeing to allow the medication to be given to the student as requested herein, I agree to indemnify and hold harmless the Archdiocese of Galveston-Houston, its servants, agents, and any employees, including, but not limited to the parish, the school, the principal, and the individuals giving the medication, of and from any and all claims, demands, or causes of action arising out of or in any way connected with the giving of the medication or failing to give the medication to the student. Further, for said consideration, I, on behalf of myself and the other parent of the student, hereby release and waive all claims, demands, or causes of action against the Archdiocese of Galveston-Houston, its agents, servants, or employees, including, but not limited to the parish, the school, the principal, and the individual giving or failing to give the medication.

Parent/Guardian Signature: _____ Date: _____

To be completed by School:

School Nurse/Health Coordinator Signature: _____ Date: _____

Principal Signature: _____ Date: _____

Before & After Program Coordinator Signature: _____ Date: _____

Teacher notification provided by: _____ Date: _____

- School staff may be notified of the student's health condition and the treatment plan in case of an emergency

INDIVIDUALIZED HEALTHCARE PLAN FOR STUDENTS WITH ASTHMA
2024-2025 SCHOOL YEAR

To be completed by the Physician:

Student's Name:_____ Date of birth:_____School:_____Grade:_____

Asthma Severity: ❒ Intermittent ❒ Mild persistent ❒ Moderate persistent ❒ Severe persistent

Asthma symptoms are triggered by: ❒ Exercise ❒ Illness ❒ Pollen ❒ Smoke ❒ Air Pollution ❒ Animals ❒ Cold Air ❒ Molds

❒ Foods: _____ ❒ Other: _____

Physical Education/Recess Plan (check all that apply)

❒ Attempt participation normally. If signs/symptoms occur stop activity and send to nurse.

❒ Not to participate in extensive running /jumping, but may walk or do other non-exertive activity.

❒ Not to participate in physical activity at specials or recess during periods of exacerbation.

❒ Other: _____

SpO_2 _____

Asthma Symptoms

- No Cough, wheeze, or shortness of breath
- Able to do all normal activities including exercise and play
- No need for quick relief medications for symptoms

TREATMENT CHECK BELOW:

❒ Use an inhaler before exercise/activity then participate normally.

_____Puffs every _____

❒ Other Medication:

_____

YELLOW ZONE

SpO_2 _____

Asthma Symptoms

- Coughing, wheezing, shortness of breath, or chest tightness.
- Using quick-relief medication more than usual
- Can do some but not all the usual activities.
- Asthma night-time symptoms

TREATMENT CHECK BELOW:

❒ Inhaler _____Puffs every _____

❒ Nebulizer

❒ Other Medication:

_____

CALL 911 for SpO_2 of _____

FOR ANY OF THESE ASTHMA SYMPTOMS!

- Medication unavailable or not working
- Chest/neck pulling in
- Difficulty walking or talking
- Getting worse, not better
- Breathing hard and fast
- Lips or fingernails blue
- Hunched over to breathe

CALL 911

TREATMENT CHECK BELOW:

❒ Inhaler _____Puffs every _____

❒ Other Medication:

_____

***ALERT EMERGENCY CONTACTS**

MEDICATION/DOSAGE

Name of Medication		When to give medication
Dosage	Frequency	May repeat _____times in _____minute intervals
Name of Medication		When to give medication
Dosage	Frequency	May repeat _____times in _____minute intervals

SELF-CARRY/SELF-ADMINISTER

Student may **SELF-CARRY** Inhaler **YES** **NO**

Student may **SELF-ADMINISTER** Inhaler **YES** **NO**

Physician initial: _____ The above student has demonstrated the proper use of his/her rescue inhaler. I have instructed the student in the correct and responsible use and confirmed that the student can carry and administer the prescribed rescue inhaler.

PHYSICIAN SIGNATURE **PHYSICIAN PRINTED NAME** **OFFICE PHONE** **DATE**