

# ASTHMA INDIVIDUAL HEALTH PLAN

(Parent/guardian to complete this form)

STUDENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ SCHOOL \_\_\_\_\_  
GRADE \_\_\_\_\_ TEACHER \_\_\_\_\_ SCHOOL YEAR \_\_\_\_\_  
PARENT/GUARDIAN \_\_\_\_\_ BEST CONTACT/PHONE NUMBER \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_  
ASTHMA SPECIALIST \_\_\_\_\_ PHONE \_\_\_\_\_

Please describe what causes your child's asthma symptoms (weather, illness, allergies, exercise, etc.):

Has your child had to go to the ER for a severe asthma episode within the past year?  Yes  No  
If yes, please describe:

Does your child take a medication at home every day to keep their asthma controlled?  Yes  No  
If yes, what medication?

Does your child have a doctor's order for emergency medication for an asthma attack to be given at school, like a rescue inhaler, and is the medication at school?  Yes  No

In addition to using a rescue inhaler, is there anything else your child does at home that helps with an asthma attack? If yes, please describe:

In the event that you cannot be reached, please list the name(s) and phone number(s) of persons who are familiar with your child's asthma and have knowledge of how to manage an asthma attack. *Please also add this person(s) to your child's pick-up list in case they may need to pick your child up from school due to their asthma.*

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Is there anything else you would like school staff to know about your child's asthma?

**PLEASE NOTE: We recommend an Emergency Action Plan, completed by a doctor, for all children with asthma.** Please review the back of this form for steps school staff may take in the event of a medical emergency. These will be followed if your child does not have an Emergency Action Plan at school for this condition.

- I give permission for my child, \_\_\_\_\_, to receive care for the medical condition listed above by designated school staff.
- School nurse may share information regarding this condition with my child's doctor.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
SCHOOL NURSE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_