Asthma Individual Health Action Plan
Board Policy 504.12-E(v)

Student Name: _____ DOB: _____

Parent/Guardian:
The following information is helpful to your child's school nurse and school staff in providing care to your child. Please complete this form and return it to your child's school nurse. A medication authorization form will need to be completed by you and your child's physician if your child needs medication at school.

Goals:

The student will communicate with school staff when experiencing asthma symptoms.
The student will have his/her needed asthma medication available and accessible at school.

Triggers of an asthma episode: (Check all that apply)

_____Exercise
_____Respiratory infections
_____Weather
_____Animals
_____Strong odors/fume
_____Emotions
_____Allergies
_____Other _____

Symptoms your child experiences during an asthma episode:

_____Wheezing _____Shortness of Breath
_____Persistent cough Other _____

Medication at school for an asthma episode:

Medication Name Dose (# of puffs)

_____

During an asthma episode at school:

1. Student will report to school staff the need to use his/her asthma medication.
2. Student will use inhaler medication or nebulizer medication as prescribed by their doctor.
3. Student will verbalize relief of asthma symptoms after use of medication before returning to classroom.
4. Contact student's parents if:

School staff will contact student's parents if:

1. Student verbalizes no relief of asthma symptoms after use of medication.
2. Student is requesting use of inhaler before the time that the prescribed dose can be repeated.

School staff will Call 911 if:

Student is struggling to breathe, there is audible wheezing, and/or skin coloring is gray or blue.

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I understand that the above plan will remain in place as long as my child is a student in the Sioux City Community School District. I understand that it is my responsibility to notify the school nurse when changes to the plan need to be made. I give permission for the information in this plan to be shared with my child's teachers, Building Emergency Response Team, School Nurse's office staff and other school staff as deemed necessary.

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Parent Signature Date