Appendix 2 – Individualized Healthcare Plan (IHP) Packet

Individualized Health Care Plan **Student Name:** Type Here **School Year:** Type Here

Asthma Individualized Healthcare Plan

SECTION I			
Student:			**WT:** / **HT:**
Grade:	**D.O.B**	**Any Known Allergies**	
School:			
District:		**Bus (check one) ☐YES ☐NO**	
		Bus #AM	**Bus #PM**
School Nurse:		**Pager #**	**Cell #**
Medication taken at home: (please list)			

Contacts			
Mother	**Home #**	**Work #**	**Pager/Cell #**
Father	**Home #**	**Work #**	**Pager/Cell #**
Guardian/Custodian	**Home #**	**Work #**	**Pager/Cell #**
Home Address		**City #**	**Zip**
Emergency Contact (Relationship)		**Home #**	**Work #**
Physician		**Phone #**	**Fax#**
Physician Address		**City**	**Zip**

Date	Special Notes

Individualized Health Care Plan **Student Name:** Type Here **School Year:** Type Here

Asthma Individualized Healthcare Plan

SECTION II: Emergency Action Plan

IF YOU SEE THIS… **Coughing, Wheezing** **Prolonged Expiration** **Tightness in Chest** **Gasping for Air** **Change in Color of Skin (Pale or Blue)**

DO THIS WHEN MEDICATION* AVAILABLE…	DO THIS WHEN MEDICATION NOT AVAILABLE…
*Med/Dose: Type Here 1. Route: ☐ Inhaler** ☐ Nebulizer 2. Observe student for change in condition 3. Allow student to return to class if symptoms Relieved/Improved after medication.	Have student sit in calm, cool environment (if possible). Have student sit upright with hands on knees (arms straight). Encourage purse-lip breathing (slowly inhale through nose and exhale through pursed-lips).
If no change in symptoms after 15 minutes of medication: *Med/Dose: Type Here 1. Route: ☐ Inhaler** ☐ Nebulizer 2. Call parent about student using medication x 2 3. Have student maintain sitting position 4. Limited physical activity.	
If no improvement in symptoms after second dose of medication and unable to contact parent after second dose is administered… 1. Call 9-1-1 (Continue trying emergency contacts) 2. Encourage slow deep breathing, rest 3. Have student maintain sitting position	
Student complains, is hunched over, has difficulty breathing, is unable to speak, uses neck/shoulder muscles to assist in breathing effort, lips and/or nail beds are blue in color 1. Call 9-1-1 2. Call parent/guardian 3. Rest, reassurance, calm slow deep breathing	
If student becomes unconscious… 1. Call 9-1-1 2. Call parent/emergency contact	**If no improvement…** 1. Call parent/emergency contact 2. Call 9-1-1

** ALL MEDICATIONS GIVEN AT SCHOOL REQUIRE A SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION SIGNED BY THE PRESCRIBER – SEE PAGE # 5*

***Proper technique for using inhaler: Have student sit upright. Remove cap; hold inhaler upright. Shake well. Tilt head slightly back, and have student breath out. Position inhaler in or near mouth or use spacer. Have student take a deep breath; press down on inhaler while student is taking a breath. Count to 10 while student holds breath.*

School Nurse Use Only

Medication	Expiration Date	Self-Carry?	Location of Medication

Asthma Individualized Healthcare Plan

SECTION III

ASTHMA is a chronic lung disease, which is characterized by attacks of breathing difficulty. It is caused by spasms of the muscles in the walls of the air passages to the lungs. It is not contagious and tends to run in families. Asthma can be aggravated by allergy to pollen or dust, viral illness, cold, emotions, or exercise. There is no cure but asthma can be controlled with proper diagnosis and management. Treatment consists of avoiding known triggers, recognizing early symptoms, monitoring with a peak flow meter, and medication to reduce or prevent symptoms. Some children who are allergic to specific substances may benefit from desensitization shots.

AVOID EXPOSURE TO KNOWN TRIGGERS (please list): Type Here

MEDICATIONS AT SCHOOL:	**POTENTIAL SIDE EFFECTS:**
Albuterol Inhaler: ☐W/SPACER ☐W/O SPACER On-Person ☐YES ☐NO Authorized to Self-Administer ☐YES ☐NO Nebulizer Treatment ☐YES ☐NO Other: Type Here	☐ Tremors - Rapid Heart Rate ☐ Headache ☐ Dizziness ☐ Dry Mouth & Throat ☐ Other: Type Here
MEDICATIONS AT HOME:	**POTENTIAL SIDE EFFECTS:**
Type Here Type Here Type Here	Type Here Type Here Type Here
CLASSROOM	**PHYSICAL EDUCATION:**
☐ Avoid all Aerosols ☐ Avoid cleaning substances with strong odors ☐ Other (please specify) Type Here Type Here Continued *Contact school nurse if student develops symptoms of acute asthma episode.*	☐ Student Requires Following Limitations: Type Here ☐ Encourage Participation, but Do Not Force ☐ Do Not Ignore Student's Symptoms. ☐ Other: Type Here *Contact school nurse if student develops symptoms of acute asthma episode.*
FIELD TRIPS:	**BUS TRANSPORTATION:**
☐ Student **IS** authorized to keep on person & self-administer inhaler: ☐ Student will keep inhaler on person at all times. ☐ Student will notify teacher/sponsor in the event inhaler is not relieving symptoms. ☐ If student exhibits signs or symptoms of distress, teacher/sponsor will active 911, notify parent, & Admin	☐ Student **IS** authorized to keep on person & self-administer inhaler. ☐ Student will keep inhaler on person at all times. ☐ If student exhibits signs or symptoms of distress, after using inhaler, bus driver will activate 911, notify parent, and administration. ☐ Other: Type Here
☐ Student **IS NOT** authorized to keep on person & self-administer inhaler: ☐ Nurse or Medication Assistant will accompany trip with medication & orders on person ☐ Student will have ready access to Nurse or Medication Assistant for duration of trip ☐ Parent will accompany trip	☐ Student **IS NOT** authorized to keep inhaler on person & self-administer inhaler. ☐ If student exhibits signs or symptoms of respiratory distress, bus driver will activate 911, notify parent, and administration. ☐ Other: Type Here
EMERGENCY DRILLS & SCHOOL CRISIS EVENTS:	**BEFORE/AFTER SCHOOL EVENTS:**
☐ In Crisis Event Follow School Safety Plan ☐ School Nurse or designated personnel will deliver medications to designated location per crisis plan. ☐ If authorized, student will keep inhaler on person Student requires mobility assistance ☐YES ☐NO ☐ If YES describe plan: Type Here	**Notes and Comments:** Type Here

Individualized Health Care Plan **Student Name:** Type Here **School Year:** Type Here

Written Notes/Addendum to Plan of Care

Date	Notes	Nurses Signature

Signature of Parent or Guardian **Date**

Signature of School Nurse **Date**

Individualized Health Care Plan **Student Name:** Type Here **School Year:** Type Here

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name: _____ **School:** _____

Date of Birth: ____/____/____ Age: _____ Grade: _____ Teacher: _____

☐ **No known drug allergies---if drug allergies list:** _____ Weight: _____pounds

PRESCRIBER AUTHORIZATION (To be completed by licensed healthcare provider)

Medication Name: _____ **Dosage:** _____ **Route:** _____

Frequency/Time(s) to be given: _____ **Start Date:** ___/___/___ **Stop Date:** ___/___/___

Reason for taking medication: _____

Potential side effects/contraindications/adverse reactions: _____

Treatment order in the event of an adverse reaction: _____

SPECIAL INSTRUCTIONS:

Is the medication a controlled substance? Yes ☐ No ☐

Is self- medication permitted and recommended? Yes ☐ No ☐

If "yes" I hereby affirm this student has been instructed On proper self-administration of the prescribe medication.

Do you recommend this medication be kept "on person" by student? Yes ☐ No ☐

Printed Name of Licensed Healthcare Provider: _____ **Phone:** ( ) _____-_____ **Fax:** _____-_____

Signature of Licensed Healthcare Provider: _____ **Date:** _____

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up with the medication.

Prescription Medication must be registered with School Nurse or trained Medication Assistants. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

Over the Counter Medication must be registered with the School Nurse or Trained Medication Assistant, OTC's in the original, unopened and sealed container. Local Education Agency Policy for OTC medication to be followed:

Parent's/Guardian's Signature: _____ **Date:** ___/___/___ **Phone:** ( ) _____-_____

SELF-ADMINISTRATION AUTHORIZATION

(To be completed ONLY if student is authorized to complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Signature of Parent: _____ **Date:** ____/____/_____ **Phone:** ( ) _____-_____

Communication of the Individualized Health Care Plan

SECTION IV

☐ Check this Box if Read Receipt is used to communicate Individualized Health Care Plan to staff.
* Nurse to attach Read Receipt document to this packet.

☐ Check this box if staff receives and signs below for Individualized Health Care Plan.

I have read and understand this student's Individualized Healthcare Plan, and have printed a copy to be maintained in my confidential folder/binder of instructions for substitute teachers.

I have been given the opportunity to ask questions.

I understand my role in addressing this students medical needs.

I am aware the school nurse is available to help clarify any future concerns

Employee Name	Employee Signature	Position	Date