

## Individualized Health Care Plan to Carry or Self-Administer Asthma Medication by a Student

To be completed by the student:

I, \_\_\_\_\_ have asthma. I may take the medication \_\_\_\_\_.

The following symptoms indicate that I need to take the medication: \_\_\_\_\_

- When I take my medication I will take \_\_\_\_\_ puffs.
- I will take it only \_\_\_\_\_ hours apart or at the times of \_\_\_\_\_.
- If there is not an improvement, I will see the school nurse, school representative, or adult who is caring for me immediately.
- I will inform the adult caring for me when I take the medication. I will inform the school nurse or school representative \_\_\_\_\_ (when) the medication is taken and document the taking of the medication. If I am at a school event or activity after school, I will inform the school nurse or school representative early the next day to document the use of the medication.
- I will never share my inhaler with anyone else.
- I will store my medication \_\_\_\_\_ while in school. While at a school-related event or activity, I will store it \_\_\_\_\_. I know a spare \_\_\_\_\_ is at School. I know there is a spare \_\_\_\_\_ when away from school.
- I will meet with the school nurse or the school representative every \_\_\_\_\_ to check on the use of my medication.
- I understand that my teachers, school nurse or school representative, and others will be monitoring my use of the medication. If there is cause the privilege will be limited or revoked.

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_

### To be completed by school nurse or school representative

The school nurse is \_\_\_\_\_. If there is not a school nurse then the person designated by the principal to administer medication is \_\_\_\_\_.

- \_\_\_\_\_ The student has demonstrated the proper use of the inhaler.
- \_\_\_\_\_ The student is capable of using the inhaler as stated.
- \_\_\_\_\_ All appropriate adults will receive an in-service.

Parent \_\_\_\_\_

School Nurse/Representative \_\_\_\_\_

Principal \_\_\_\_\_

Teacher \_\_\_\_\_

As appropriate: Coach \_\_\_\_\_

Before/After Program Coordinator \_\_\_\_\_

Student \_\_\_\_\_

Date \_\_\_\_\_

Physician \_\_\_\_\_

Date \_\_\_\_\_

Reference: Asthma and Allergy Foundation of American, 1233 20<sup>th</sup> St, NW Suite 402, Washington, DC 20036 \* www.aafa.org\* 1-800-ASTHMA