

# 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: \_\_\_\_\_

G R E E N  Z O N E	<p>SpO<sub>2</sub> _____</p> <p><b>Asthma Symptoms</b></p> <ul style="list-style-type: none"> <li>No Cough, wheeze, or shortness of breath</li> <li>Able to do all normal activities including exercise and play.</li> <li>No need for quick relief medications for symptoms</li> </ul> <p><b><u>TREATMENT CHECK BELOW:</u></b></p> <p><input type="checkbox"/> Use an inhaler before exercise/activity then participate normally. _____ Puffs every _____</p> <p><input type="checkbox"/> Other Medication: _____</p>	Y E L L O W  Z O N E	<p>SpO<sub>2</sub> _____</p> <p><b>Asthma Symptoms</b></p> <ul style="list-style-type: none"> <li>Coughing, wheezing, shortness of breath, or chest tightness.</li> <li>Using quick-relief medication more than usual</li> <li>Can do some but not all the usual activities.</li> <li>Asthma night-time symptoms</li> </ul> <p><b><u>TREATMENT CHECK BELOW:</u></b></p> <p><input type="checkbox"/> Inhaler _____ Puffs every _____</p> <p><input type="checkbox"/> Nebulizer</p> <p><input type="checkbox"/> Other Medication: _____</p>	R E D  Z O N E	<p>CALL 911 for SpO<sub>2</sub> of _____</p> <p><b>FOR ANY OF THESE ASTHMA SYMPTOMS!</b></p> <ul style="list-style-type: none"> <li>Medication unavailable or not working.</li> <li>Chest/neck pulling in.</li> <li>Difficulty walking or talking.</li> <li>Getting worse, not better</li> <li>Breathing hard and fast</li> <li>Lips or fingernails blue</li> <li>Hunched over to breathe.</li> </ul> <p style="text-align: right; color: red; font-weight: bold; font-size: 1.5em;">CALL 911</p> <p><b><u>TREATMENT CHECK BELOW:</u></b></p> <p><input type="checkbox"/> Inhaler _____ Puffs every _____</p> <p><input type="checkbox"/> Other Medication: _____</p> <p style="text-align: center; background-color: #cccccc; font-weight: bold; font-size: 0.8em;">*ALERT EMERGENCY CONTACTS</p>
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**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 <b>SELF-CARRY</b> Inhaler	<b>YES</b>	<b>NO</b>
Student may <b>SELF-ADMINISTER</b> Inhaler	<b>YES</b>	<b>NO</b>
<p><b>Physician initial:</b> _____ 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.</p>		

**PHYSICIAN SIGNATURE**

*Updated January 2024*

**PHYSICIAN PRINTED NAME**

Archdiocese of Galveston-Houston | Catholic Schools Office, 2024-2025

**OFFICE PHONE**

**DATE**

**SELF-CARRY AND SELF-ADMINISTER ASTHMA RESCUE INHALER AGREEMENT  
2024-2025 SCHOOL YEAR**

***To be completed by the Parent and Student:***

Student name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Where will the student carry an inhaler (**required**): \_\_\_\_\_

Additional inhalers will be provided to the school and stored with prescribed medication at specified school locations:

**(required)**: \_\_\_\_\_

**STUDENT**

- I agree to carry my rescue inhaler with me as listed above and if an emergency arises and I am unable to get to the nurse/school personnel I will use the rescue inhaler and then immediately inform a nurse/school personnel to document the usage.
- I agree to use my rescue inhaler responsibly, following the physician's orders. I understand my asthma triggers, symptoms, and treatment plan reviewed by my physician and parent(s)/guardian(s) and understand how to use my rescue inhaler when an emergency arises, and I am unable to get to the nurse/school personnel in time.
- I will notify school personnel if I am having more difficulty than usual with my asthma.
- I agree to never share my rescue inhaler with another person as this is dangerous and if I do this may result in disciplinary action.

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

**PARENT/GUARDIAN**

- I agree to see that my child carries his/her rescue inhaler as prescribed and that it is properly labeled and is not expired.
- I understand that I will provide the school with an inhaler to store at school along with any prescribed medication from the physician's treatment plan.
- I have reviewed with my child the asthma triggers, symptoms, and treatment plan including the usage of the self-carry rescue inhaler when an emergency arises.
- I agree to regularly review with my child the proper use of his/her rescue inhaler when at school.
- I agree to regularly review the status of my child's asthma with the physician and to notify the physician when my child is having more difficulty than usual.
- I understand if my child shares medication with other students it may result in disciplinary actions.
- My child has demonstrated to his/her physician 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.
- The self-administration is done in compliance with the prescription or written authorization for my child to self-administer the medicine while on school 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 instructions of my child's physician. Additionally, I have provided a written and signed statement from my child's physician that states:
  1. The student has asthma and can self-administer the prescription medicine.
  2. The name and purpose of the medicine; the prescribed dosage of the medicine; the times or circumstances in which the medicine may be administered; and the duration for which the medicine is prescribed.
- This is in effect for the current school year only unless revoked by the physician or the student, parent(s)/guardian(s) fails to meet all the above safety contingencies.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_