ARLINGTON PUBLIC SCHOOLS
EDUCATE • PREPARE • INSPIRE

Asthma Individual Health Care Plan

School year

Student legal last name | First name | MI

Birth date | School | Grade | Other ID#

Transportation: ☐ Walker ☐ Self Transported ☐ Bus Rider | Bus Route Number

Parent/Guardian Information

Parent/Guardian | Primary phone - -

Work phone - - | Cell phone - -

Parent/Guardian | Primary phone - -

Work phone - - | Cell phone - -

Healthcare Provider and Hospital Information

Healthcare Provider Name | Phone - -

Preferred Hospital | Phone - -

Medical Information

Current Medications (Rescue & Maint.)

Asthma History

Triggers

Special Precautions

Medication Orders

Medication Name | Dose | When

It is medically necessary for this student to carry an inhaler during school hours ☐ Yes ☐ No

Student may self-administer inhaler ☐ Yes ☐ No Student has demonstrated use to Licensed Healthcare Professional ☐ Yes ☐ No

Healthcare Provider Name *(Printed)* | Phone - - | Fax - -

Healthcare Provider Signature | Date

Emergency Intervention

(Not all students will experience all symptoms during an asthma attack)

Moderate Symptoms	Immediate Response
Excessive coughing	Accompany student to health room (do not send alone)
Wheezing	Give medication as prescribed by IHP
Shortness of breath	Keep student sitting up and reassure student
Chest tightness	Encourage to relax and take deep slow breaths
Nostrils flaring	Encourage student to drink warm water
Shoulders hunched over	Stay with student until improvement noted
Anxious or scared	Contact School Nurse
Peak flow to	Contact parent/guardian if no improvement after 15-20 minutes

Severe Symptoms	Immediate Response
Lips or nail beds turning gray or blue (student with light complexion)	**Call 911**
Paling of lips or nail beds (students with dark complexions)	Notify Parent/Guardian
Grunting	Notify School Nurse
Inability to speak in complete sentences without taking a breath	Notify School Principal
Severe restlessness	**Do not leave the student unattended**
Decreasing or loss of consciousness	

Emergency Contacts

Name _____ Phone ___ - ___ - ____ Relationship _____

Name _____ Phone ___ - ___ - ____ Relationship _____

Name _____ Phone ___ - ___ - ____ Relationship _____

Parent/Guardian Signature _____ Date _____

School Nurse Signature _____ Date _____

Healthcare Provider Signature _____ Date _____

A copy of this plan will be kept in the school health room and the information will be shared with others who will need to know to maintain the child's health and safety.

CONFIDENTIAL INFORMATION/SHRED PRIOR TO DISCARDING