



UNIVERSITY SCHOOL

EAST TENNESSEE STATE UNIVERSITY

68 Martha Culp Drive, Johnson City, TN 37614

Phone: (423) 439-8674 Fax: (423) 439-5921

Asthma Individual Health Plan

STUDENT _____ DOB _____ GRADE _____

IF STUDENT COMPLAINS OF ASTHMATIC ILLNESS / EXHIBITS:

- | | |
|-------------------------------------|---|
| 1. Tightness in chest | 6. Inability to speak in full sentences without taking a breath or only able to whisper |
| 2. Shortness of breath | 7. Bluish discoloration of lips, nails, mucous membranes around eyes/gums |
| 3. Coughing for prolonged periods | 8. Coughing that causes choking, a bluish color to lips, or persistent vomiting |
| 4. Audible wheeze or unusual sounds | 9. Need to stand or lean over at waist |
| 5. Anxious appearance | 10. Decreased level of consciousness |

INHALER REQUIRED FOR SCHOOL: YES _____ NO _____ LOCATION OF INHALER: _____

STUDENT WILL CARRY INHALER AT ALL TIMES: YES _____ NO _____ (IF STUDENT CARRIES INHALER, IT IS RECOMMENDED THAT A SECOND INHALER BE KEPT IN CLINIC)

DO THE FOLLOWING:

- Student should be allowed to use his/her asthma medication per below.
- Student to go immediately to office/clinic accompanied by peer/school personnel. When student says s/he is unable to walk to office/clinic, call for medication to be brought immediately to student. (Medication located: _____).
- Call for medication to be brought to student, immediately, by school nurse (when in building); otherwise call the main office.

Student / Nurse/ First Responder to administer medication listed below. Review five R's to assure the student is taking the right medication. Right student, Right medication, Right dose, Right time, Right route.

Name of Medication: _____ Dose: _____ Route: _____ Time(s) to be administered: _____

Stay with student and remain calm. Monitor for symptoms above.

- When symptoms decrease 15 minutes after taking medications; student may return to class.
- When symptoms increase in severity or there is absent breathing/pulse/decreased level of consciousness, delegate call to EMS/911, and begin CPR as necessary.
- Notify parent promptly of incident and action taken.
- Encourage student to relax by:
 - > Assuming most comfortable position or placing hands/arms over head.
 - > Doing slow, deep breathing.
 - > Sipping warm water/tea.
 - > Refocusing on pleasant images/thoughts.

EXERCISE AND SPORTS PARTICIPATION GUIDELINES

- [] NO RESTRICTIONS- Included interscholastic athletics, contact sports.
- [] MODERATE EXERCISE- Includes physical education classes and recreational sports, but should avoid activities which require maximum or sustained effort.
- [] LIGHT EXERCISE- Included nonstrenuous recreational games such as swimming, jogging, bowling, (modified gym program without being graded recommended).
- [] Must be permitted to determine his/her own level of activity and to stop and rest if needed.
- [] NO PHYSICAL EDUCATION CLASSES

The parent signature below gives permission for the school nurse or representative to fax this form to the indicated PCP and to communicate with said PCP, the PCP's office staff, and the ETSU University School faculty/staff regarding this health plan for the student named above, and their care. It is the parent's responsibility to share this information with other staff you deem necessary (i.e. teachers, coaches, etc.). Your signature below indicates your understanding and agreement with this policy.

Physician/PCP Name/Office Name
Physician/PCP Phone & Fax Number: _____

Parent Contact
Phone _____

Physician Signature
Date _____

Parent Signature
Date _____