SUMTER COUNTY SCHOOLS
INDIVIDUALIZED HEALTH CARE PLAN ASTHMA / REACTIVE AIRWAY DISEASE

Date Initiated: _____
Date Reviewed: _____
Date Reviewed: _____
Date Discontinued: _____

Student Name: _____ DOB: _____ School: _____ Grade: _____
Parent/Guardian: _____ Contact #'s: Home _____ Cell _____ Work _____
_____ Home _____ Cell _____ Work _____
Other Emergency Contacts: _____ Contact #: _____
_____ Contact #: _____
Physician: _____ Phone#: _____ Fax #: _____

Medical Diagnosis: _____ Allergies: _____ Medications at Home: _____ at School: _____

History of Severe Allergies Yes No **ESE:** Yes No **IEP:** Yes No **504:** Yes No

Parent Signature: _____ Date _____ Nurse Signature _____ Date _____
Preferred Hospital: _____

Nursing Diagnosis	Goals	Nursing Interventions	Outcomes/ By Whom/When
1. __ Potential for severity of asthma, respiratory distress; Ineffective airway clearance	1. ___ Student will maintain health and well being necessary for learning.	1.__ Student will be monitored for any of the following signs/symptoms of Asthma: • persistent coughing • Difficulty breathing or coughing • audible wheezing • clearing throat • flaring nostrils • blue lips • chest retraction • decreased breath sounds and wheezing with auscultation • anxiety, panic	School nurse, school health staff, school personnel – ongoing

		2. If noted, or student c/o symptoms: __ Student will be sent to school clinic for medication administration as ordered by health care provider. __ Student will carry and self administer medication as ordered by health care provider. __If symptoms do not significantly improve in **_____ minutes** repeat medication as ordered by healthcare provider. __If symptoms still do not improve or condition worsens and parent/guardian can't be reached: __ **CALL 911 (EMS)**	School personnel Student – if appropriate and required paperwork on file at the school School nurse, school health staff, school personnel
2.___ Risk for non-compliance with treatment regimen related to: • knowledge deficit about asthma. • trigger avoidance • improper administration of medication • denial • perceived ineffectiveness of medication •inability to access medication	1. __Student will learn the importance of medication compliance to maintain optimum health. 2. ___ Student will have needed asthma medication available and easily accessible.	1. __Student will be notified to come to school health clinic for medication if student does not report within **_____ minutes** of scheduled time. 2. __Parent will maintain an adequate supply of medication at school. 3. __Parent will be notified when medication needs to be replenished. 4.__Parent/guardian will provide all necessary equipment and supplies for student's medical needs.	School Nurse, teacher, school health staff, school personnel as needed Parent/guardian School Nurse, school health staff, school personnel Parent/guardian
3. __Potential for respiratory distress and activity intolerance related to physical activity/strenuous exercise/exercise induced asthma	1.__ Student will be able to participate in all school activities including play, exercise and sports, while maintaining optimum respiratory status.	1.__ Student and school personnel will report and note any signs of increased respiratory distress. 2.__ Staff will allow rest periods as needed during physical activity/strenuous exercise. 3.__ When student is unable to participate in physical activity, an alternate activity will be substituted.	Student, school nurse, school health staff, school personnel – ongoing School personnel, as needed Teacher, classroom instructor, as needed

		4. __Student will report to the school health clinic for asthma inhaler **_____ minutes** before physical activity, as ordered by physician. 5. __ Student has the following restrictions per physicians orders: _____ _____ _____	Student, teacher, school nurse, school health staff, school personnel Teacher, school personnel, per physician orders
4.__ Potential for poor gas exchange related to: • Broncospasm • Inflammation of the airway	1.__Maintain near normal pulmonary function. 2.__ Student will be able to identify symptoms of a severe allergic reaction. 3. Staff will be able to identify symptoms of a severe allergic reaction. 4. Identify persons who have access to and know where medication(s) are stored.	1.__ Student will report to the school health clinic, per physician's order, to monitor respiratory status using peak flow meter. • Normal volume: _____ • Low volume: _____ 2.__ Volume will be recorded in student record. 3.__ If peak flow volume is **below _____** administers medication as ordered by physician and contact parent/guardian. 4.__ If peak flow meter is **below _____ Call 911 (EMS)** and notify school administrator and parent 5. __ Review symptoms and source of allergen as well as sign and symptoms of a severe allergic reaction. 6. Train staff about reaction/anaphylaxis/EAP **Document name of trained staff** 7. __ Personnel _____ Date: _____ __ Personnel _____ _____ __ Personnel _____ _____ __ Aide _____ _____ __ Aide _____ _____ __ Aide _____ _____	Student, as ordered School nurse, school health staff, school personnel School nurse, school health team, school personnel School nurse, school health staff, school personnel School nurse

		__ Bus Driver _____ _____ __ Other _____ _____	
5.__ Potential need for medication for management of asthma	1.__ Maintain near normal pulmonary function; prevent asthma symptoms and recurrent asthma episodes.	1.__ Student will report to the school health clinic for medication administration according to physician's orders. **Medication(s) Dose Time** _____ _____ _____ 2.__ Student may receive medication by nebulizer, if ordered. Follow procedure in school health manual. 3.__ Student will be monitored for lack of improvement in symptoms after administration of medication. 4.__ Student will be reminded to come to the school health clinic for medication if student does not report within **_____minutes** of scheduled time. 5.__ Student will carry and self administer inhaler as ordered by healthcare provider and with consent of the parent. 6.__ Parent will be notified if there are any concerns regarding student's health status which might require medical follow-up. 7.__ This plan also covers field trips/after school activities. Discussion with parents in advance of activities so that medical needs can be accomplished. Trained school staff will accompany student on off campus trips, if needed.	Student, school nurse, school health staff, school personnel, as ordered by physician School nurse, school health staff, school personnel, as ordered by physician - ongoing Teacher, school nurse, school health staff, school personnel - ongoing Teacher, school staff, school nurse, school personnel – as specified Student,, school nurse, school health staff, parent as ordered by physician School nurse, parent, school health staff, school personnel, student Trained school personnel

☐ **Obtained via telephone interview with parent School Year _____**

☐ **Obtained via telephone interview with parent School Year _____**

☐ **Obtained via telephone interview with parent School Year _____**

*** As parent/guardian by signing this Health Care Plan, I authorize designated Sumter County School personnel, Sumter County Health Department School personnel, and any other contracted health care agencies to provide emergency care for my child and/or to share or exchange medical information as necessary to support the education and continuity of care of my child. I also give permission for the Sumter County Schools to share this information with faculty/staff who are directly involved in my child's education.**

***Note: 1. Significant changes to the health plan of care requires a new Individual Health Care Plan be completed.**
2. At the beginning of the 4th school year based on the initial date of this plan a new IHCP will be written.