# SUMNER COUNTY SCHOOLS
# IHP/SAFETY PLAN: ASTHMA DISORDER
**This portion is to be completed by a PARENT/GUARDIAN**

**Child Information**

Name of Child:____________________________________Date of Birth________________

Child's Age________Grade______Homeroom Teacher_____________________________

**Emergency Information**

Emergency Contact: ________________________ Relationship: ________________________

Phone 1: ______________________________ Phone 2: __________________________

Parent/Guardian: ____________________ Phone 1: _______________ Phone 2: ______________

Pulmonologist: ______________________________ Phone: ________________________

Primary Physician: ____________________________ Phone: ________________________

**Date of last ASTHMA ATTACK:** ______________________

**Triggers that may bring on an asthma episode:**

- ☐ **Respiratory Infection** ☐ **Exposure to Cold/Temperature Changes** ☐ **Cigarette Smoke**
- ☐ **Odors/Fumes** ☐ **Exercise**
- ☐ **Allergic Reaction to:** ________________________________________
- ☐ **Other:** ________________________________________________

**Please check the signs/symptoms your child displays during an asthma event:**

- ☐ **Shortness of Breath** ☐ **Bluish Color to Nails/Skin** ☐ **Coughing** ☐ **Wheezing** ☐ **Anxiety**
- ☐ **Difficulty Talking in Complete Sentences**
- ☐ **Other:** ________________________________________________

**List ALL current medications (Home and School):**

| Medication | Dosage/Strength | Purpose | Time of Day | School OR Home |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**My child has the following other chronic illnesses/disabilities**: __________________________

**Allergies:**________________________________________________________

**Child's Limitation or Special Considerations:**__________________________________

It is understood that any medication is administered solely at the request of and as an accommodation to the undersigned parent or guardian. I understand that I am responsible for furnishing all medications. The school nurse has permission to communicate with the healthcare provider regarding this medication and plan of care including, but not limited to, orders, clarification of orders, etc. I understand that the health care provider may disclose protected health information in consultation with the school nurses. All information obtained will remain confidential and be available on a need-to-know basis to those individuals who are involved in providing for your child's health and educational needs at school. In consideration of the acceptance of the request to perform this service by any person employed by the Sumner County School System, the undersigned parent or guardian hereby understands and agrees that the Sumner County School System and its personnel shall not be liable for any injury resulting from the reasonable and prudent administration of medication or the reasonable performance of health care procedures, including the administration of medication (T.C.A. § 49-5-415). By signing, parent indicates agreement with the plan of action as described by health care provider.

- ☐ Student information was requested from the parent with no response. This IHP was developed from the school nurse without input from the parents.

Parent/Guardian Signature: ______________________________ Date: __________________

School Nurse Signature: ________________________________ Date: __________________

**BACK PAGE TO BE COMPLETED BY PHYSICIAN**

## SUMNER COUNTY SCHOOLS
## ASTHMA IHP/SAFETY PLAN-PRESCRIPTION MEDICATION ORDERS
**This portion is to be completed by the PHYSICIAN**

Name of Child: ______________________________________________ DOB: ___________________

**ASTHMA RISK**: Mild _____ Moderate _____ Severe _____

**Protocol/Procedure for student having an asthma attack:**
1. **Encourage student to remain calm, take slow, deep breaths, and sit upright.**
2. **Allow student to administer prescribed asthma medication (if available).**
3. **Stay with student and monitor response.**
    - **If symptoms decrease within 15 minutes and student is relieved, he/she may return to class.**
    - **If symptoms persist after 15 minutes contact SET/School Nurse, call parent AND PROCEED TO EMERGENCY ACTION PLAN BELOW.**

EMERGENCY ACTION PLAN
1. **If in doubt, activate EMS/Call 911.**
2. **Stay with student and continue to monitor breathing and general condition.**
3. **Allow student to take additional prescribed, rescue medications or doses as ordered (if available).**
4. **SET/School Nurse will assess student, utilize pulse oximeter and provide Oxygen support as needed (when available).**

**Emergency Medication(s) to be Administered at School During Acute Asthma Episode**

| Name of Medication | Strength and Dose to be Given | When to Administer at School | Possible Side Effects of Medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**If peak flow meter used, please specify parameter:** ______________________________________________

**For Inhaled Medications (Please check <u>ONE</u> of the following):**

**_____ I have instructed this student in the proper way to use their inhaled medications. It is my professional opinion that he/she should be <u>ALLOWED TO CARRY</u> and use their prescribed inhaler.**

**_____ It is my professional opinion that the student <u>SHOULD NOT</u> carry his/her inhaled medications, but should receive assistance with administration by an adult.**

**This child has the following additional chronic illnesses/disabilities:** ___________________________________
______________________________________________________________________________

**Physician's Signature:** ________________________________________ **Date:** ______________________

**Physician's Name (Print):** ______________________________________ **Phone:** _____________________

**FRONT PAGE TO BE COMPLETED BY <u>PARENT</u>**

*4/2016*