Asthma Individual Health Plan

F17

Student _____ **Student ID#** _____ **Birthdate** _____

School _____ **Grade/Room** _____

Parent/Guardian _____ **Phone** _____

Primary Care Provider _____ **Phone** _____

Assessment Data: (check or circle if applicable)

Signs/symptoms
___ wheezing
___ difficulty breathing
___ chest tightness
___ cough
___ other (describe):
_____
_____
_____

Triggers
___ exercise
___ cold air
___ dust
___ stress
___ infection
___ allergies
(describe):
_____
_____

___ chalk/markers
___ perfumes
___ smoke
___ air fresheners
___ animals
(describe)::
_____
_____
_____

Attendance Issues
Y/N school
Y/N physical ed.
Y/N classroom
Y/N recess

Student's Strengths
___ has developed age appropriate self management skills
___ good problem solving ability
___ communicates needs
___ accepts diagnosis
___ effective coping skills
___ good social skills
___ other_____

Predicted peak flow _____
Personal best peak flow
_____

Frequency of asthma episodes _____
Number of hospitalizations _____
(in the last 12 months)

Has positive support system
___ Yes ___ No
Describe _____

Family Resources:
1. Has phone: Y / N/ Sometimes
2. Utilizes primary clinic: Y / N/ Sometimes
3. Utilizes community resources: Y / N/ Sometimes
4. Has transportation: Y / N/ Sometimes
5. Receives preventive care: Y / N/ Sometimes
6. Housing meets family needs Y/ N/ Sometimes

Comments

Current medications: home (h) and school (s), including OTC and alternative meds

Name	Route	Dose	Frequency

IEP: Y/N Primary disability_____ Receiving special education nursing services: Y/N D(min)____ Ind(min)____
Adaptations: Asthma needs noted Y/N (attach)

504 Plan: Y/N (attach)

Nursing Diagnosis:
1. Potential for alteration in respiratory function.
2. Potential for less than optimal school achievement due to asthma.
3. Other (describe)_____.

Goals:
1. Increase knowledge &/or skills related to asthma to maintain near normal pulmonary function.
2. Participate in regular school/class activities, including physical education class, with modifications made as necessary.
3. Other (describe)_____.

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Interventions: (Check if applicable)

First Aid ___ loosen clothing ___ encourage relaxation ___ encourage pursed lip breathing
___ use peak flow meter ___ administer medication
___ administer room temperature fluids by mouth if able to swallow
___ other _____

Referral/s (to clinic, home care, other community agency,etc.)_____

Parent /Guardian action/education _____

Asthma Education/Self Management Skills (Education code *– see below)

	Date	Date	Date	Date	Date		Date	Date	Date	Date	Date
What is asthma?						Correct peak flow meter techniques					
AAP – knows zones and action						Knowledge of Triggers					
S/S, warning signs						Environmental control					
Correct inhaler technique						Techniques for staying active					
Correct neb technique						Medication Review					

*Document date, education code U/N and initials for each encounter (U=understands N=needs more information)

Comments/Progress toward goals:

Student Out Comes:

1. Student will participate in classroom/school activities with modifications as needed.
2. Student will improve or maintain understanding of checked items under Asthma Education/Self Management Skills.
3. Other (describe)_____

Plan initiated: **Date:** _____ **LSN Signature** _____

Date: _____ **Parent /Guardian Signature**_____

Date: _____ **Student Signature** _____

Plan reviewed: **Date:** _____ **LSN Signature** _____

Date:_____ **LSN Signature**_____

Date:_____ **LSN Signature**_____