****

**Individualiz­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ed School Healthcare Plan (ISHP)**

**Please attach applicable procedure and physician’s orders to this ISHP**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Student Name:** |  | **DOB/ID #:** |  | **Date:** |  |
| **School Site:** |  | **Rm. #** |  | **School Phone:** |  |

|  |
| --- |
| **Physician Information:** |
| Name:  | Phone:  |  |
| **Emergency Contacts:** |
| **Name** | **Relationship** | **Phone** | **Phone** | **Phone** |
| 1.  |  |  |  |  |
| 2.  |  |  |  |  |
| 3.  |  |  |  |  |
| **MEDICAL DIAGNOSIS/PROBLEM AND DESCRIPTION:** |
| Asthma is a condition in which your airways narrow and swell and may produce extra mucus. This can make breathing difficult and trigger coughing, a whistling sound (wheezing) when you breathe out and shortness of breath.Ineffective airway clearance associated with chronic inflammation causing bronchoconstriction and excessive mucus production. Deficient knowledge about asthma and asthma self-careFor some people, asthma is a minor nuisance. For others, it can be a major problem that interferes with daily activities and may lead to a life-threatening asthma attack. |
| **SYMPTOMS TO WATCH FOR:** |
| Asthma symptoms vary from person to person. You may have infrequent asthma attacks, have symptoms only at certain times — such as when exercising — or have symptoms all the time.Asthma signs and symptoms include:* Shortness of breath
* Chest tightness or pain
* Wheezing when exhaling, which is a common sign of asthma in children
* Trouble sleeping caused by shortness of breath, coughing or wheezing
* Coughing or wheezing attacks that are worsened by a respiratory virus, such as a cold or the flu
 |
| **HEALTH CARE ACTION PLAN:** |
| * Obtain an Asthma Action Plan from the parents/guardians and the healthcare provider.
* Identify the student’s level of asthma severity by monitoring peak flows and asthma signs and symptoms to help in establishing priority for intervention.
* Ensure that quick-relief medication is easily and quickly available to the student.
* The student will have an Asthma Action Plan on file in the school health office to be used in developing an IHP.
* The student will demonstrate proper technique for using asthma medications and medication delivery devices.
* The student will assist in making sure that necessary medication is easily accessible and available.
* Educate teachers and other school personnel about the student’s asthma, monitoring of student’s symptoms, and means to implement the asthma management plan.
* The student will identify his/her asthma triggers and list strategies for how to avoid these or how to control exposure to them.
* The student will identify the responsibilities for self-carrying of medication and demonstrate safe use of self-carry medications.
 |
| **IN THE EVENT OF AN EMERGENCY EVACUATION** |
| The following designated and trained staff member(s): should have access to a communication device and are responsible for assuring that the student’s medication and emergency plan accompanies him/her to the evacuation command center.The following designated and trained staff member(s): are responsible to evacuate the student following the pre-determined (attached) path of travel. If the student is unable to ambulate or utilize his/her powerchair/wheelchair, then the Med-Sled must be used to evacuate. The Med Sled is located:  |
| **STUDENT ATTENDANCE** |
| [ ]  **No Concerns** [ ]  **Concerning Absenteeism (5 – 9.9%) Chronic Absenteeism (> 10%)****INTERVENTIONS**[ ]  **Parent/Guardian Contact** [ ]  **Attendance letter**[ ]  **HIPAA/MD Contact** [ ]  **Medical Referral**[ ]  **Teacher(s) Collaboration** [ ]  **SART/SARB** |
| **DESIGNATED STAFF:** |
| **Name** | **Training Date** | **Name** | **Training Date** |
| 1.  |  | 4.  |  |
| 2.  |  | 5.  |  |
| 3.  |  | 6.  |  |
| **DISTRIBUTION DATE(S):** |
| [ ]  **Principal** | **Date** |  | [ ]  **Parent/Guardian** | **Date** |  |
| [ ]  **Teacher** (Put copy in sub folder) | **Date** |  | [ ]  **Other** |  | **Date** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **School Nurse Signature** |  | **Date** |  |
| **Parent/Guardian Signature** |  | **Date** |  |