**Logo, company name

Description automatically generated**

**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-care  For 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** |  |