



**Klamath Falls
City Schools**

100% Graduation is Our Expectation!

Individual Health Plan
Asthma Action Plan

Effective Date: _____

Student: _____ School Year: _____ Grade _____ Teacher _____

Emergency contact _____ Phone numbers _____

Physician/health care provider _____ Phone numbers _____

Allergies: _____

ACTION PLAN

| SEVERITY CLASSIFICATION (See other side – Medical Provider’s Section) | TRIGGERS | | ACCOMMODATIONS NEEDED (See other side – medical provider’s section) |
|---|--|--|---|
| <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent | <input type="checkbox"/> Exercise <input type="checkbox"/> Pollens <input type="checkbox"/> Molds <input type="checkbox"/> Smoke <input type="checkbox"/> Weather <input type="checkbox"/> Pets <input type="checkbox"/> Strong emotions | <input type="checkbox"/> Car/bus fumes <input type="checkbox"/> Dust/carpet <input type="checkbox"/> Strong odors (e.g., cleaning products, perfumes) <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Student uses an inhaler <input type="checkbox"/> Student has permission to carry an inhaler <input type="checkbox"/> Inhaler kept in office <input type="checkbox"/> Exercise modifications: _____ <input type="checkbox"/> Other: _____ |

IF YOU SEE THIS

DO THIS

Breathing is good/ no cough or wheeze heard
Can play, walk, and talk without problems

May need to use inhaler prior to physical activity
Use inhaler as directed on prescription label

IF YOU SEE THIS

DO THIS

Coughing or wheezing heard
States that chest “feels tight,”
Has shortness of breath
Has signs of a “cold” (congestion, etc)
Has been exposed to a known “trigger”

Stay with child, remain calm, have child rest & sit up
Use peak flow meter (if at school), recheck in 15 min.
Have student use inhaler or nebulizer per provider orders
If no improvement in 15 min, call contact person and school district nurse

If condition worsens, call 9-1-1

IF YOU SEE THIS

DANGER SIGNS

DO THIS

Has difficulty walking/talking/ straining to breathe
Breathing is hard and fast/ student is hunched over
Lips or fingernails look gray or blue
Chest and neck “pulls in” with breathing/ ribs show/
Nostrils wide open

Delegate **CALL** to **9-1-1** and parent
Delegate call to contact person and school district nurse
Do not leave student unattended

Signing this individual health plan authorizes permission for the school nurse to share information on a “need to know” basis, including information about diagnosis and the disease process, management of the condition including specific management details for the student, emergency management, and information that may affect the student’s educational goals. This information may be shared with education, transportation, and nutrition staff.



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Individual Health Plan
Asthma Action Plan

In accordance with SB 1040-ACCA 7/07 (section 3a) requiring the medical provider to formulate a written treatment plan for managing the student’s asthma at school and for use of medication by the student during school hours;

The top section on this side is to be completed by a medical authority.

MEDICAL PROVIDER ORDERS:

SEVERITY/CLASSIFICATION: Intermittent Mild Persistent Moderate Persistent Severe

Bronchodilator (inhaler) prescribed: _____

Oral medication prescribed: _____

Other asthma medication: _____

Prescriber gives permission for student to carry and self-medicate; student has demonstrated capability and responsibility in its correct usage.

Student is not ready to self-medicate at school; follow school policy and procedures on previous page.

Physical activity may trigger an asthma episode

Physical Limitations include no _____

Peak flow meter Independent in use and interpretation (supervise only) Needs assistance

Other instructions: _____

Medical Provider’s signature _____ **Printed name** _____

Medical facility _____ **Phone** _____ **Date** _____

Health Care Provider permission to carry and self-medicate may be revoked or denied by the building administrator or the district nurse if it is determined that the student cannot safely and effectively self-administer the medication or abuses the use of the medication

School Use Only:

Asthma Action Plan and Medical Provider Orders Reviewed

By: _____ Date _____

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