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
IHP/SAFETY PLAN: ASTHMA DISORDER

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: _____

11/2023