



WASHINGTON COUNTY DEPARTMENT OF EDUCATION
Coordinated School Health

University School

Phone: (423) 439-8674

Fax: (423) 439-5921

STUDENT _____ DOB _____ TEACHER _____ GRADE _____

IF STUDENT COMPLAINS OF ASTHMATIC ILLNESS / EXHIBITS:

- 1. Tightness in chest
2. Shortness of breath
3. Coughing for prolonged periods
4. Audible wheeze or unusual sounds
5. Anxious appearance
6. Inability to speak in full sentences without taking a breath or only able to whisper
7. Bluish discoloration of lips, nails, mucous membranes around eyes/gums
8. Coughing that causes choking, a bluish color to lips, or persistent vomiting
9. Need to stand or lean over at waist
10. Decreased level of consciousness

INHALER REQUIRED FOR SCHOOL: YES _____ NO _____ LOCATION OF INHALER: _____
STUDENT WILL CARRY INHALER AT ALL TIMES: YES _____ NO _____ (IF STUDENT CARRIES INHALER, IT IS RECOMMENDED THAT A SECOND INHALER BE KEPT IN CLINIC)

DO THE FOLLOWING:

- Student should be allowed to use his/her asthma medication per below. OR
Student to go immediately to office/clinic accompanied by peer/school personnel.
When student says s/he is unable to walk to office/clinic, call for medication to be brought immediately to student. (Medication stored: _____) OR

Call _____ medication to be brought to student, immediately, by school nurse (when in building); otherwise first responder(s) _____.

Student / Nurse/ First Responder to administer medication listed below. Review five R's to assure the student is taking the right medication. Right student, Right medication, Right dose, Right time, Right route.

Name of Medication: _____ Dose: _____ Route: _____ Time(s) to be administered: _____

Stay with student and remain calm. Monitor for symptoms above.

- When symptoms decrease 15 minutes after taking medications; student may return to class.
When symptoms increase in severity or there is absent breathing/pulse/decreased level of consciousness, delegate call to EMS/911, and begin CPR as necessary.
Notify parent promptly of incident and action taken.
Encourage student to relax by:
Assuming most comfortable position.
Doing slow, deep breathing.
Sipping warm water/tea.
Refocusing on pleasant images/thoughts.

EXERCISE AND SPORTS PARTICIPATION GUIDELINES

- NO RESTRICTIONS- Included interscholastic athletics, contact sports.
MODERATE EXERCISE- Includes physical education classes and recreational sports, but should avoid activities which require maximum or sustained effort.
LIGHT EXERCISE- Included nonstrenuous recreational games such as swimming, jogging, bowling, (modified gym program without being graded recommended).
Must be permitted to determine his/her own level of activity and to stop and rest if needed.
NO PHYSICAL EDUCATION CLASSES

This Individualized Health Plan will be shared with trained personnel and Coordinated School Health Staff. It is the parent's responsibility to share this information with other staff you deem necessary (i.e. teachers, coaches, etc.). Your signature below indicates your understanding and agreement with this policy.

Physician Name: _____

Phone: _____

Parent Signature _____

Date _____

Physician Signature _____

Date _____

Parent Contact _____

Phone _____

