Asthma Individualized Healthcare Plan (IHCP)

Student:_____ID#:_____DOB: _____
Grade:_____Teacher:_____School Year:_____
Student's Seconday Health Concerns: _____

Nursing Diagnoses: Knowledge Deficit Related to Disease Management & Prescribed Treatment Regimen (NANDA 00126)
Ineffective Airway Clearance (NANDA 00031)
Student Goal(s): Student Will Demonstrate Understanding of the Disease Process and Management
Student will Maintain Effective Airway Clearance

Ratings: 1- No Knowledge, 2- Limited, 3- Moderate, 4- Substantial, 5- Extensive Knowledge (Circle One)

Student Knowledge: Disease Process

	Date:_____	**Date:** _____	**Date:**_____	**Date:** _____
Able to Describe Common Signs & Symptoms of the Disease	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Able to Describe Cause , Contributing Factors and triggers.	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Describe Potential Complication of Disease	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Verbalizes Lifestyle Changes that may be Required to Prevent Future Complications and/or Control the Disease Process	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Student Kowlegde: Asthma Management

Knowledge of Treatment Regimen & compliance	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Knows Importance of Continual Access to inhaler	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Verbalizes understanding on when to Use Prescribed Medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Knows When to Seek Medical Attention/Emergency Treatment	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Understands treatment effectiveness	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Routinely monitor expiration date	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Medication Administration

Identification & Correct Name of Medication	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Correct Use of Prescribed Medication (Correct Dose, Time, Route)	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Able to Verbalize Medication Side Effects	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Performance & Evaluation of Procedure	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Confidence Performing Needed Task	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Ratings: 1- Severely Compromised, 2- Substantially, 3- Moderately, 4- Mildly, 5- Not Compromised, N/A- Not Applicable (Circle One)

Student Health Status

Physical Health	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Mental Health	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
School Attendance	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Readiness to Learn	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Participation In Physical Activities	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A
Healthy Dietary Habits	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A	1 2 3 4 5 N/A

Completed by:	**Completed by:**	**Completed by:**	**Completed by:**
Nurse's Signature:	**Nurse's Signature:**	**Nurse's Signature:**	**Nurse's Signature:**

Additional Notes:_____

_____

_____

_____

_____

_____

Florida Miami Dade DOH School Health Program
Roles & Responsibilities: Asthma

Student:_____**ID#:** _____
Grade:_____**DOB:**_____**Teacher:** _____
Parent/Guardian Name(s)_____**School Year:**_____

School Responsibilities/Agreements	Family Responsibilities/Agreements	Student Responsibilities/Agreements
1. Medication & Supplies Kept: Circle below where applicable- Clinic Main Office Classroom Student Book Bag Other:_____	1. Provide medication & supplies for school site. Pick up and replace any expired medication. Med Name & Exp. Date: _____ Med Name & Exp. Date: _____	1. Report any early signs/symptoms of asthma to school staff.
2. UAP to administer medications per MDCPS training (review action plan, recognize symptoms & respond): _____ _____	2. Keep school staff informed of any changes in student condition, medications and updated emergency contact information. Any change in medication regimen requires new medication forms.	2. If applicable, carry asthma medication as directed by physician.
3. Staff to contact 911/Parent/Guardian in case of an emergency: Administration	3. Available to accompany student on field trip and carry asthma medication.	3. Demonstrate competence in the use of asthma medication.
3. Staff to direct EMS to the emergency: Administration & Security	4. If applicable, check student is carrying asthma medication as directed by physician.	
4. CPR certified staff: _____ _____	5. Pick up any unused medication at the end of the school year.	
5. Security/Teacher to carry school two-way radio and/or have emergency intercom access		
6. Substitute Teacher Instructions: Copy of Action Plan on Lesson Plan		

_____ _____
Parent/Guardian Signature Date

_____ _____
Principal or School Administration Designee Name Date

_____ _____
School Nurse Date

School Health Program

Student Asthma Checklist

Student Name: _____ **ID#:**_____

School Nurse: _____ **Date:** _____

The student has demonstrated understanding and competency consistently to:

SKILLS	YES	NO	COMMENTS
I. Identify asthma triggers			
2. Identify signs and symptoms of asthma episode or early distress			
3. State knowledge of medication: A. Correct name and expiration date B. Side effects C. Adverse reactions D. Appropriate use of medication per order E. Appropriate use of equipment/device(MDI, inhaler, flow meter and nebulizer)			
4. Understands the importance to alert staff of poor response to self-administered medication			
5. State the need to call 9-1-1			

The student agrees to follow the safety precautions with medication compliancy and report any signs distress.

Student Signature_____ Date: _____

Parent Name/Signature_____ Date_____

I hereby acknowledge that the student listed above has demonstrated all the above listed skills.

School Nurse Signature_____ Date_____

Review Dates: _____ _____ _____ _____ _____ _____ _____

Asthma Skills Checklist for Delegation to Unlicensed Assistive Personnel (UAP)

Student Name:_____DOB:_____Grade: _____

Person Trained:_____Position:_____

School Nurse:_____School Year:_____

Instructions: Place on X over entire area of Medication/Equipment not applicable to student
Ratings: Y- Yes, N- No, N/A- Not Applicable (Circle One)

	Training & Return Demo Date	Monitoring Date	Monitoring Date
Metered-Dose Inhaler (MDI)/Autohaler	_____	_____	_____
Identifies & States Name of MDI	Y N N/A	Y N N/A	Y N N/A
States the Purpose for use of MDI	Y N N/A	Y N N/A	Y N N/A
States Symptoms of Asthma Attack	Y N N/A	Y N N/A	Y N N/A
States Location of Medication & Emergency Care Plan	Y N N/A	Y N N/A	Y N N/A
Follows procedure for use of MDI	Y N N/A	Y N N/A	Y N N/A
Identifies and correct problems with technique	Y N N/A	Y N N/A	Y N N/A
Assesses response to medication	Y N N/A	Y N N/A	Y N N/A
Responds appropriately to poor response to medication	Y N N/A	Y N N/A	Y N N/A
Valved Chamber/Spacer			
Identifies & States Name of Spacer	Y N N/A	Y N N/A	Y N N/A
Follows procedure for assembly of inhaler with spacer	Y N N/A	Y N N/A	Y N N/A
States the Purpose for use of Spacer	Y N N/A	Y N N/A	Y N N/A
Identifies and correct problems with technique	Y N N/A	Y N N/A	Y N N/A
Compressor/Nebulizer/Inhalation Solution			
Identifies & States Name of Inhalation Solution/Nebulizer	Y N N/A	Y N N/A	Y N N/A
States the Purpose for use of Inhaltion Solution/Nebulizer	Y N N/A	Y N N/A	Y N N/A
Follows procedure for assembly of Nebulizer	Y N N/A	Y N N/A	Y N N/A
States Symptoms of Asthma Attack/Need for Medication	Y N N/A	Y N N/A	Y N N/A
States Location of Medication & Emergency Care Plan	Y N N/A	Y N N/A	Y N N/A
Follows procedure for use of Inhalation Solution/Nebulizer	Y N N/A	Y N N/A	Y N N/A
Identifies and correct problems with technique	Y N N/A	Y N N/A	Y N N/A
Assesses response to medication	Y N N/A	Y N N/A	Y N N/A
Responds appropriately to poor response to medication	Y N N/A	Y N N/A	Y N N/A
	Nurse's Signature	Nurse's Signature	Nurse's Signature
	_____	_____	_____
	UAP Signature	UAP Signature	UAP Signature
	_____	_____	_____

Asthma Skills Checklist for Delegation to Unlicensed Assistive Personnel (UAP)

Student Name:_____DOB:_____Grade: _____

Person Trained:_____Position:_____

School Nurse:_____School Year:_____

Instructions: Place on X over entire area of Medication/Equipment not applicable to student
Ratings: Y- Yes, N- No, N/A- Not Applicable (Circle One)

Metered-Dose Inhaler (MDI)/Autohaler	**Training & Return Demo Date** _____	**Monitoring Date** _____	**Monitoring Date** _____
Identifies & States Name of MDI	Y N N/A	Y N N/A	Y N N/A
States the Purpose for use of MDI	Y N N/A	Y N N/A	Y N N/A
States Symptoms of Asthma Attack	Y N N/A	Y N N/A	Y N N/A
States Location of Medication & Emergency Care Plan	Y N N/A	Y N N/A	Y N N/A
Follows procedure for use of MDI	Y N N/A	Y N N/A	Y N N/A
Identifies and correct problems with technique	Y N N/A	Y N N/A	Y N N/A
Assesses response to medication	Y N N/A	Y N N/A	Y N N/A
Responds appropriately to poor response to medication	Y N N/A	Y N N/A	Y N N/A
Valved Chamber/Spacer			
Identifies & States Name of Spacer	Y N N/A	Y N N/A	Y N N/A
Follows procedure for assembly of inhaler with spacer	Y N N/A	Y N N/A	Y N N/A
States the Purpose for use of Spacer	Y N N/A	Y N N/A	Y N N/A
Identifies and correct problems with technique	Y N N/A	Y N N/A	Y N N/A
Compressor/Nebulizer/Inhalation Solution			
Identifies & States Name of Inhalation Solution/Nebulizer	Y N N/A	Y N N/A	Y N N/A
States the Purpose for use of Inhaltion Solution/Nebulizer	Y N N/A	Y N N/A	Y N N/A
Follows procedure for assembly of Nebulizer	Y N N/A	Y N N/A	Y N N/A
States Symptoms of Asthma Attack/Need for Medication	Y N N/A	Y N N/A	Y N N/A
States Location of Medication & Emergency Care Plan	Y N N/A	Y N N/A	Y N N/A
Follows procedure for use of Inhalation Solution/Nebulizer	Y N N/A	Y N N/A	Y N N/A
Identifies and correct problems with technique	Y N N/A	Y N N/A	Y N N/A
Assesses response to medication	Y N N/A	Y N N/A	Y N N/A
Responds appropriately to poor response to medication	Y N N/A	Y N N/A	Y N N/A
	Nurse's Signature	Nurse's Signature	Nurse's Signature
	_____	_____	_____
	UAP Signature	UAP Signature	UAP Signature
	_____	_____	_____

8020 & 8080
Child-Specific Training for School Staff

School:

Student: **Date**
ID #
DOB:
Health Condition:

Teacher Name	Subject	Signature	Level 2	Level 3

School Nurse: