LEGACY
CHRISTIAN ACADEMY

picture

Individualized Health Care Plan

Asthma

Name of Student:_____

Grade:_____ **Homeroom:**_____ **Bus rider** **yes** ☐ **no** ☐ **Bus #**____

Additional Health Concerns:_____

_____

Accommodations needed for classroom or school environment:_____

_____

Daily Asthma Management Plan

Asthma Triggers		
☐ Exercise	☐ Food	☐ Mold
☐ Respiratory infections	☐ Animals	☐ Other
☐ Changes in temperature	☐ Pollen	
☐ Strong odors	☐ Dust	

Additional Instructions:_____

_____

Student has an Emergency Action Plan: yes ☐ **no** ☐
Medication to be taken prior to exercise: yes ☐ **no** ☐ **PE Days:**_____
Peak Flow Monitoring: Personal Best Peak flow number:_____**; Monitoring Times:**_____

Medications to be taken at school:

Medication	**Amount**	**Time**

The school nurse has consent to share this information with the appropriate staff: yes ☐ **no** ☐

Parent/Guardian Signature: _____ Date:_____

School Nurse Signature:_____ Date:_____ _____

Any revision to the student's IHP/EAP requires a new form to completed and dated by the parent.