INDIVIDUAL HEALTH CARE PLAN

Name: **Grade** **Teacher:**

History: Asthma

Assessment Data	Nursing Diagnosis	Nursing Interventions	Goals	Evaluation Criteria
History of asthma Potential triggers: ● Chalk dust ● Colds/flu ● Dust, carpet, stuffed animals ● Exercise ● Mold ● Ozone ● Pets, plants, flowers, cut grass, pollen ● Strong odors, perfumes, cleaning products ● Sudden temperatu re change ● Smoke ● Foods: ● Other:	Potential for alteration in respiratory function. Potential for alteration in activity tolerance related to asthma	1. Implement the Asthma Action Plan. 2. Monitor onset & timing of symptoms, effectiveness of medication, and any other asthma management measures used. 3. Assist student in complying with Asthma Action Plan. 4. Assist physical education teachers to modify class activities as needed. 5. Inservice appropriate staff on asthma management.	Maintain near normal pulmonary function. Implement asthma action plan prepared by the physician. Participation in regular school activities, including physical education, with modifications as necessary. Compliance with prescribed asthma management plan	The student will follow their asthma action plan. The student will participate in regular physical education activities, with modifications made when necessary. The student will recognize early signs of an asthma episode, stop the activity, if applicable, and inform the teacher when having an asthma episode.

For Self Administration: I further acknowledge that the North Brunswick Township School District shall incur no liability as a result of any injury arising from administration of the medication to my child. If procedures specified by NJ law and the North Brunswick School District Policy are followed, I shall indemnify and hold harmless the North Brunswick School District and it's employees or agents against any claims arising out of administration of medication to my child.

Parent Signature Date

I will take the responsibility of educating and instructing the bus drivers and substitute bus drivers of my child's special medical needs as I feel may be necessary.

Parent Signature Date

Medical Doctor's Signature Date Medical Doctor's Name