

**PARENT WILL NEED TO FILL OUT THIS PAGE:**

Student Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_

Homeroom Teacher:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year:\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Nursing Diagnosis  (ND) | Nursing Intervention | Nursing goals/outcomes |
| 1. Ineffective airway clearance related to airway spasm, secretion retention, amount of mucus. 2. Potential for ineffective breathing pattern related to spasm of the airway, respiratory muscle fatigue. | \*Encourage the student to increase fluids.  \*Encourage student to maintain medication regimen prescribed by MD.  \*Monitor the chest wall retraction, respirations, and lung sounds. (ND2)  \*Administer asthma medications per MD order & have Asthma Action Plan on file.  \*If no Action plan or MD order on file, contact parent and/or call 911 if needed. | \*The student will maintain a patent airway and not experience adverse symptoms  \*Student will not experience respiratory difficulty.  \*Student will maintain health and well being necessary for learning and Action Plan will be on file. |

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(parent/guardian) authorize to the school nurse &/or the school Administration to designate a school personnel(s)(who will not need a medical or nursing license) to assist &/or observe my child taking the prescribed medication which is(name of medication) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and to perform and carry out the care as outlined in (student’s name )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Individualized Healthcare Plan. I also consent to the release of the information contained in this Individualized Healthcare Plan to all school personnel(s) and other adults who have responsibility for my child and who may need to know this information to maintain my child’s health and safety. I consent to communication between the prescribing physician, the school nurse, and the designated school personnel (which is assigned by the school administration) necessary for the management and administration of medications pertaining to my child’s medical condition addressed on this Individualized Healthcare Plan.

**Parent/guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_**

**Emergency contact person(s) 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**