Chesterfield County Public Schools
Student Health Services

Dear Parent/Guardian:

Providing a safe, supportive and nurturing environment is a goal of Chesterfield County Public Schools (CCPS)**.** The health information provided for your child indicates that he/she has a health concern. To adequately meet your child's health needs while in school, please do the following as soon as possible:

1. Have your licensed healthcare provider (physician, physician's assistant or nurse practitioner) complete and sign the attached Individualized Healthcare Plan (IHP). IHPs are also available online at http://mychesterfieldschools.com/parents/student-health-and-safety/.

2. Provide your signature on the IHP.

3. Return the completed plan to the attention of the school nurse at the school your child will be or is attending.

It may be necessary for some students to carry and self-administer emergency medication. This requires proper documentation by a licensed healthcare provider on the appropriate health plan. Permission for a student to possess and self-administer medication (for example auto-injectable epinephrine or medication to manage asthma or diabetes) is effective for one school year and must be renewed annually. Please consult with your school nurse for details.

If medication is needed for your child, complete the CCPS School Medication Record form required for all medications that students take during the school day. This form is available in the school clinic and at http://mychesterfieldschools.com/parents/student-health-and-safety/**. Medication must be provided by the parent/guardian and brought to school by the parent/guardian in the original appropriately labeled container. See the CCPS website for details regarding the medication policy and regulation (4130 and 4130R).**

For students with a life-threatening food allergy, the Food Allergy Medical Statement must be completed by a physician, physician's assistant or nurse practitioner if the child needs any of the following: to be identified by cafeteria staff as having a life-threatening allergy; if child is lactose intolerant; if substitutions or food modifications need to be made in the school breakfast or lunch programs. The Cafeteria Manager at school must also be notified. For assistance you may contact the Nutritionist, CCPS Food & Nutrition Department, at (804) 743-3717.

A health condition may be considered a disability. If you suspect your child may have a disability, ask your child's teacher, Counselor, school nurse or administrator for a referral to consider eligibility for 504 or special education services.

If you have any questions, call the registered nurse at your child's school. We appreciate your prompt attention to this matter. Thank you for partnering with us to support your child's well-being in school.

Sincerely,

Chesterfield County Public Schools
Student Health Services

1st notice _____

2nd notice _____

Attachment

Healthcare Plan effective for current school year, including summer school.

Chesterfield County Public Schools
School Health Services

Individualized Healthcare Plan - Asthma

Student Name: _____ **Date of Birth:** _____ **School:** _____

To be completed by LICENSED HEALTHCARE PROVIDER (Physician, Physician's Assistant or Nurse Practitioner

What triggers child's asthma?

☐ Illness/colds ☐ Smoke ☐ Strong odors ☐ Pollen ☐ Dust ☐ Mold/moisture ☐ Dog ☐ Cat ☐ Exercise ☐ Acid reflux
☐ Stress/Emotions ☐ Season/Weather _____ ☐ Food:_____ ☐ Other_____

What symptoms does child experience during an asthma episode? (Check all that apply)

☐ Cough ☐ Shortness of breath ☐ Tightness in chest ☐ Wheezing ☐ Tired/weak ☐ Other_____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise Induced

WELL Zone: GO! — Student will take these CONTROL (PREVENTION) medications EVERY day

Student has ALL of these:

- Breathing is easy
- No cough or wheeze
- Can work and play without activity restrictions
- Able to sleep through the night
- Peak flow: _____ to _____ (More than 80% of Personal Best)

Personal best peak flow:_____

Inhaled controller medications taken at home:

☐ Aerospan ☐ Advair ☐ Alvesco ☐ Asmanex ☐ Budesonide ☐ Dulera
☐ Flovent ☐ Pulmicort ☐ QVAR ☐ Symbicort ☐ Other: _____

_____ puffs inhaler _____times a day OR _____nebulizer treatment(s) _____times a day

☐ (Montelukast) Singulair _____ by mouth once daily at bedtime

For asthma with exercise, ADD:
INHALER: ☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent),
2 puffs with spacer 15 minutes before exercise (PE class, recess, sports)

☐ No control medications required.

SICK Zone: CAUTION! — Give RESCUE Medications

Student has **ANY** of these:

- Cough or mild wheeze
- Tightness in chest
- Difficulty breathing
- Not able to do usual activities
- Problems sleeping at night
- Peak flow: _____to _____ (60% - 80% of Personal Best)

INHALER:

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
_____ puffs with spacer every _____ hours as needed

NEBULIZER:

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
one unit dose treatment every _____ hours as needed

SCHOOL ACTION: Call 911 if no improvement or symptoms worsen.
Call parent if use of medication does not relieve student's symptoms.

Parent/student action: Call Healthcare Provider if you need rescue medicine for more than 24 hours or two times a week, or if your rescue medicine doesn't work.

EMERGENCY Zone: DANGER! — Call 911 and treat as below

Student has **ANY** of these:

- Can't talk, eat, or walk well
- Medicine not helping
- Breathing hard and fast
- Blue or gray lips or fingernails
- Tired or lethargic
- Chest or neck pulls in with breathing
- Peak flow: less than _____ (Less than 60% of Personal Best)

INHALER:

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
_____puffs with spacer **every 15 minutes**, for **THREE** treatments

NEBULIZER:

☐ Albuterol ☐ Levalbuterol (Xopenex) ☐ Ipratropium (Atrovent)
one unit dose treatment **every 15 minutes**, for **THREE** treatments

SCHOOL ACTION: Call 911 immediately. Call parent.

Parent/student action: Seek emergency medical treatment for your child NOW.

(OVER—See Other Side)

Individualized Healthcare Plan - Asthma

Student Name: _____ **Date of Birth:** _____

To be Completed by LICENSED HEALTHCARE PROVIDER (Physician, Physician's Assistant or Nurse Practitioner)

1.	Student's inhaler needs to be with him/her at all times.	☐ YES	☐ NO
2.	Student's inhaler needs to be on the bus.	☐ YES	☐ NO
3.	Student can physically carry inhaler.	☐ YES	☐ NO (If NO, inhaler will be kept with a supervising adult)
4.	Student needs supervision or assistance to use inhaler.	☐ YES	☐ NO
5.	Student has been instructed in proper use of inhaler, and in my opinion, can self-administer inhaler at school.	☐ YES	☐ NO

Additional Comments or Instructions: _____

_____

_____

_____ _____ _____

Licensed Healthcare Provider Name (PRINT) **Licensed Healthcare Provider Signature** **Date** **Phone Number**

To be Reviewed and Signed by PARENT/GUARDIAN:

- I understand school staff and/or the school health nurse may communicate with the Licensed Healthcare Provider/medical office staff about this health plan.
- I understand I am responsible for providing the school with all medication for my child in the original container per Chesterfield County School Board policy 4130/4130R *Administration of Medication to Students.*
- I understand I am responsible for completing the Chesterfield County Public Schools School Medication Record for medication ordered in this health plan.
- I understand emergency medication I provide will be administered as ordered by the Licensed Healthcare Provider.
- **I agree to this health plan for my student.**

_____ _____ _____

Parent/Guardian Signature **Parent/Guardian Name (print)** **Date** **Phone Number**

_____ _____ _____

School Nurse Name/Signature **Date Received** **Date Emergency Action Plan Distributed**

Based on Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 04/2015
Based on NAEPP Guidelines 2007 and modified with permission from the D.C. Asthma Action Plan via District of Columbia, Department of Health, DC Control Asthma Now, and District of Columbia Asthma Partnership

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