Houston Independent School District **ASTHMA ACTION PLAN/IHP**

Student's Name: _____ Date of birth: _____ Student ID Number: _____ Grade: _____ Medication Allergies: _____

Asthma symptoms are triggered by: ❒ Exercise ❒ Illness ❒ Pollen ❒ Smoke ❒ Air Pollution ❒ Animals ❒ Cold Air ❒ Molds ❒ Foods (list) _____

❒ Other (list) _____

If a student has *any* of the following symptoms: chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath:

1. **Stop activity & help student to a sitting position**
2. **Stay calm, reassure student**
3. **Assist student with the use of their inhaler**
4. **Escort student to the school clinic or call for nurse for immediate assistance. Never send the student to the clinic alone!**

INHALER IS KEPT: ❒ **In School Clinic** ❒ **Self Carry**

CALL 911 FOR ANY OF THESE!

- **If breathing does not improve after medication is given**
- **Student is having trouble walking or talking**
- **Student is struggling to breathe**
- **Student's chest and/or neck is pulling in while breathing**
- **Student's lips are blue, and/or**
- **Student must hunch over to breathe**

***HEALTH CARE PROVIDER, Please* complete *all* items in box:**

Asthma Severity: ❒ Intermittent ❒ Mild persistent ❒ Moderate persistent ❒ Severe persistent

Controller Medication given at home:

_____ _____

Name of Medication 1/How much?/How often? **Name of Medication 2/How much?/How often?**

GREEN ZONE

*Peak Flow _____
80 to 100% of personal best

Asthma Symptoms

- No Cough, wheeze or shortness of breath
- Able to do all normal activities including exercise and play
- No symptoms at night
- No need for quick relief medications for symptoms

Exercise Induced Asthma: Use quick relief inhaler before exercise as ordered below:

_____
Name of medication/How much/How often

YELLOW ZONE

*Peak Flow _____
50 to 80% of personal best

Asthma Symptoms

- Coughing, wheezing, shortness of breath, or chest tightness
- Using quick relief medication more than usual
- Can do some but not all of usual activities
- Asthma night time symptoms

Add or change these medications (see below):

_____
_____
Name of medication/How much/How often

_____
❒ nebulizer _____

_____
Parent/guardian-call medical provider if using quick relief medication more than twice a week or no symptom improvement

RED ZONE

*Peak Flow _____
Less than 50% of personal best

Asthma Symptoms

- Medication unavailable or not working
- Getting worse not better
- Breathing hard and fast
- Chest/neck pulling in
- Difficulty walking or talking
- Lips or fingernails blue
- Hunched over to breathe

Take Quick Relief Medication Now!
***Call 911* & continue to give Quick Relief Medication every 20 minutes until EMS arrives!**
Add or change these medication (see below):

_____
Name of medication/How much/How often

_____
❒ nebulizer _____
Other Emergency meds _____
Contact Parent & Provider-See Contact Info Below

Date: _____ **Provider signature** _____ **Provider Printed Name** _____

Provider phone _____ **Fax** _____ **Parent Signature** _____

SELF-ADMINISTRATION: ❑ ***By checking THIS box AND signing ABOVE, the Health Care Provider and parent, give written authorization of permission for this child to self-carry and self-administer prescription asthma medication during school or at school-related events.***

Implementation of these orders and care includes authorization to contact and discuss this condition and elements of care with healthcare providers

Parent/Guardian signature _____ Date _____

Home phone/cell _____ Work phone _____ Alternative contact # _____

School Nurse Signature _____ Date _____ Phone _____ Fax _____

White Copy - School Yellow Copy - Parent English Pink Copy - Parent Spanish Goldenrod Copy - Dr.

Rev.: 6/4/2010

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Asthma Severity: ❒ Intermittent ❒ Mild persistent ❒ Moderate persistent ❒ Severe persistent

Controller Medication given at home:

_____ _____

Name of Medication 1/How much?/How often? **Name of Medication 2/How much?/How often?**

GREEN ZONE

*Peak Flow _____
80 to 100% of personal best

Asthma Symptoms

- No Cough, wheeze or shortness of breath
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Exercise Induced Asthma: Use quick relief inhaler before exercise as ordered below:

_____
Name of medication/How much/How often

YELLOW ZONE

*Peak Flow _____
50 to 80% of personal best

Asthma Symptoms

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- Can do some but not all of usual activities
- Asthma night time symptoms

Add or change these medications (see below):

_____
_____
Name of medication/How much/How often

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❒ nebulizer _____

_____
Parent/guardian-call medical provider if using quick relief medication more than twice a week or no symptom improvement

RED ZONE

*Peak Flow _____
Less than 50% of personal best

Asthma Symptoms

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- Chest/neck pulling in
- Difficulty walking or talking
- Lips or fingernails blue
- Hunched over to breathe

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Distrito Escolar Independiente de Houston **PLAN DE ACCIÓN PARA EL ASMA**

Nombre del estudiante:_____ Fecha de nacimiento:_____ Nº de identificación:_____ Grado: _____ Alergias a drogas:_____

Los síntomas del asma son debidos a: ❒ Ejercicio ❒ Enfermedad ❒ Polen ❒ Humo ❒ Contaminación del aire ❒ Animales ❒ Aire frío ❒ Mohos ❒ Comidas (Escriba)_____

❒ Otro (Escriba) _____

Si el estudiante tiene *cualquiera* de los siguientes síntomas: presión en el pecho, dificultad para respirar, jadeo, tos excesiva, respiración leve:

1. **Detener actividad y ayudar al alumno a que se siente.**
2. **Mantener la calma y confortar al estudiante**
3. **Asistir al alumno con e uso del inhalador**
4. **Escoltar al alumno a la oficina de la enfermera o llamar inmediatamente a la Enfermera. ¡Nunca enviar al alumno solo a la oficina de la enfermera!**

EL INHALARDOR ESTÁ: ❒ En la oficina de la enfermera ❒ Lo tiene el alumno

¡LLAME A 911 SI EL NIÑO TIENE CUALQUIERA DE ESTOS SÍNTOMAS!

- **La respiración no mejora después de tomar el medicamento.**
- **El alumno tiene dificultad para caminar y hablar.**
- **El estudiante tiene dificultad para respirar.**
- **El estudiante siente que el cuello y pecho se tensa al tratar de respirar.**
- **Los labios del alumno se ponen de color azulado.**
- **El alumno debe doblarse para tratar de respirar.**

MÉDICO O PROVEEDOR DE CUIDADOS DE SALUD **Complete *todos* los puntos en el casillero**

Severidad del asma: ❒ Intermitente ❒ Persistente pero leve ❒ Persistente y moderada ❒ Persistente y severa

Medicamento para el control de la enfermedad en el hogar:

_____ _____

Nombre del primer medicamento/Cantidad/Frecuencia **Nombre del sugundo medicamiento/Cantidad/Frecuencia**

ZONA VERDE

*Capacidad de respiración _____
De 80 a 100% de capacidad máxima

Síntomas del asma

- No tiene tos, no jadea ni tiene dificultad para respirar.
- Puede hacer todas las actividades normales, incluyendo jugar y hacer ejercicio.
- No tiene síntomas a la noche.
- No necesita medicamento para alivio rápido (inhalador) para eliminar los síntomas.

Asma causada por ejercicios:
Usa inhalador antes de ejercitar, según la siguiente orden médica:

_____
Nombre del medicamento/Cantidad/Frecuencia

ZONA AMARILLA

*Capacidad de respiración _____
De 50 de 80% de capacidad máxima

Síntomas del asma

- Toser, jadear, dificultad para respirar o presión en el pecho.
- Usa más de lo usual el medicamento para alivio rápido (inhalador).
- Puede hacer ciertas, actividades.
- Síntomas de asma en la noche.

Agregar o cambiar estos medicamentos (Ver abajo):

_____

_____
Nombre del medicamento/Cantidad/Frecuencia

_____

❒ nebulizador _____

_____
El padre o tutor legal debe llamar al médico si se usa el medicamento para alivio rápido (inhalador) más de dos veces por semana o los síntomas no desaparecen.

ZONA ROJA

*Capacidad de respiración _____
Menos de 50% de capacidad máxima

Síntomas del asma

- No hay medicamento disponible o no funciona
- Empeorar
- Respirar rápido y con esfuerzo
- Presión en pecho y cuello
- Dificultad para caminar o hablar
- Labios y uñas azuladas
- Doblar la espalda al respirar

¡Usar inmediatamente el medicamento para alivio rápido (inhalador)!
***Llamar al 911* y seguir tomando ese medicamento cada 20 minutos hasta que llegue personal de emergencia.**
Agregar o cambiar estos medicamentos (Ver abajo):

_____
Nombre del medicamento/Cantidad/Frecuencia

_____

❒ nebulizador _____

Otras drogas de emergencia _____

Contactar a padre y médico –Ver información abajo

Fecha:_____ **Firma del médico**_____ **Nombre del Médico (en imprenta)**_____

Teléfono (médico) _____ **Fax** _____ **Firma del padre o tudor legal** _____

AUTOADMINISTRACIÓN: ❑ ***Al marcar ESTE casillero Y firmar ARRIBA, el médico y padre dan autorización escrita para que el niño lleve consigo y se auto suministre el medicamen prescrito para el asma durante el día escolar o en los eventos relacionados a la escuela.***

La implementación de estas órdenes y cuidados incluye la autorización para contractar y dialogar sobre esta enfermedad y su cuidado con los médicos y otros proveedores de salud

Firma del padre o tutor legal _____ Fecha _____

Teléfono del hogar/celular _____ Teléfono del trabajo _____ Número de contacto adicional _____

Firma de enfermera escolar _____ Fecha _____ Teléfono _____ Fax _____

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