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 _____