



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 _____

It is the policy of the Houston Independent School District not to discriminate on the basis of age, color, handicap or disability, ancestry, national origin, race, religion, sex, veteran status or political affiliation in its educational or employment programs and activities.



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

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

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Parent/Guardian signature _____ **Date** _____

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

School Nurse Signature _____ **Date** _____ **Phone** _____ **Fax** _____

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Nombre del estudiante: _____ Fecha de nacimiento: _____ N° 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 el uso del inhalador**
- 4. Escotar 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 INHALADOR 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 segundo medicamento/Cantidad/Frecuencia

Z O N A V E R D E	*Capacidad de respiración _____ De 80 a 100% de capacidad máxima	Z O N A A M A R I L L A	*Capacidad de respiración _____ De 50 de 80% de capacidad máxima	Z O N A R O J A	*Capacidad de respiración _____ Menos de 50% 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 _____		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.		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 tutor 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 medicamento 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** _____

Las directivas del Distrito Escolar Independiente de Houston prohíben cualquier tipo de discriminación en base a edad, color, discapacidad, ascendencia, nacionalidad, estado civil, raza, religión, sexo, ser veterano de guerra, o afiliación política en sus programas y actividades académicas y en el empleo de individuos.



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