**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

❒ 2 or ❒ 4 puffs, every 20 minutes for up to 1 hour

❒ 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):**

_____ ❒ 4 or ❒ 6 puffs
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