EL PASO INDEPENDENT SCHOOL DISTRICT

*Division of Special Education and Special Services*
***Health Services Department***

# Asthma Action Plan 20___to 20___

**Student's Name: _____ID#:_____ DOB: _____**
**School: _____ School Phone#: _____School Fax#: _____**
**Significant Medical History/ Diagnosis: _____**
**Allergies: _____**
**Asthma Triggers Identified: ☐Exercise ☐ Colds ☐ Smoke (fire, tobacco, incense) ☐Pollen ☐Dust ☐Strong Odors ☐Mold/Moisture ☐Stress ☐Pests ☐Gastroesophageal Reflux ☐Season: Fall, Winter, Spring, Summer ☐Animals ☐Other (food allergies) _____**
**Emergency Contact: _____Emergency Phone#:_____**

**Health Care Provider: Please complete Severity Level, Zone Information and Medical Order Below**
**Asthma Severity: ☐Intermittent or Persistent: ☐Mild ☐Moderate ☐Severe**

| **Green Zone: GO –You're Doing Well!! Take Control Medications EVERYDAY to Prevent Symptoms** | |
|---|---|
| You have **ALL** of these:<br>• Breathing is easy<br>• No cough or wheeze<br>• Can work and play<br>• Sleep through the night<br><br>Peak flow may be useful for some students | ☐ **NO** Controller medication is prescribed<br>☐ _____,_____puff(s) MDI _____ times a day<br>☐ _____,_____Nebulizer Treatment _____ times a day<br>☐ _____ ☐ _____<br>**For asthma with exercise give:**<br>☐ _____ _____<br>**Inhalers work better with spacers. Always use a mask when prescribed.** |
| **Yellow Zone: Slow Down!** | **Continue Green Zone Medicine and Add:** |
| You have **ANY** of these:<br>• **First signs of cold**<br>• Cough or mild wheeze<br>• Exposure to know trigger<br>• Tight Chest<br>• Coughing at nigh<br>Peak flow may be useful for some students | **DO NOT LEAVE STUDENT ALONE! Call Parent/Guardian when rescue medication is given**<br>☐ _____,_____puff(s)every_____ minutes/hours PRN (circle)<br>**OR**<br>☐ _____,_____Nebulizer Treatment _____minutes/hoursPRN (circle)<br>If you **are getting worse or not improving** after treatment(s) **GO TO RED ZONE** |
| **Red Zone: DANGER—GET HELP!** | **TAKE THESE MEDICATIONS NOW AND GET MEDICAL HELP NOW!** |
| Your asthma is<br>**getting worse fast:**<br>• Cannot talk, eat or walk well<br>• Medicine is not helping<br>• Getting worse, not better<br>• Breathing is hard & fast<br>• Getting nervous | **DO NOT LEAVE STUDENT ALONE!**<br>**Call 911 and start treatment then call Parent/Guardian**<br>☐ _____ _____ until EMS arrives<br>☐ Check saturation with Pulse Oximeter continually until EMS arrives. |

**I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the current school year or until there is a change or cancellation of the procedure(s) during the current school year.**

## Inhaler is kept:

☐ **with Student**

☐ Is student capable of self-administration

☐ do you recommend that this child carry his/her own inhaler

☐ Student is to notify Nurse or UAP after use of inhaler at school.

To Be Completed by a Licensed Practitioner:

**Length of Time for Present School Year:**

**Yes_____ No_____**

If No for how long? _____

_____

**Practitioner's Signature**

_____

**Practitioner's Name** **Date**

_____ _____

**Office Phone Number** **Fax Number**

To Be Completed by The Parent/Guardian

☐ Yes ☐ No My child has my permission to carry his/her inhaler as ordered by the practitioner.

☐ Yes ☐ No I give permission for my child to have his/her inhaler administered by trained school personnel.

Signature :_____

Printed Name:_____

Date:_____ Relationship:_____

**I, the undersigned, as the physician for the above-named student, approve the following health care procedure(s) to be administered to this student during school hours by trained staff. I agree that this authorization for the procedure(s) will stand for the current school year or until there is a change or cancellation of the procedure(s) during the current school year.**

## Inhaler is kept:

☐ **with Nurse in Health Office**

☐ Student needs supervision or assistance with using inhaler

☐ Student is unable to carry his/her inhaler while at school.

To Be Completed by a Licensed Practitioner

**Length of Time for Present School Year:**

**Yes_____ No_____**

If No for how long? _____

_____

**Practitioner's Signature**

_____

**Practitioner's Name** **Date**

_____ _____

**Office Phone Number** **Fax Number**

To Be Completed by The Parent/Guardian

☐ Yes ☐ No My child has my permission to carry his/her inhaler as ordered by the practitioner.

☐ Yes ☐ No I give permission for my child to have his/her inhaler administered by trained school personnel.

Signature:_____

Printed Name:_____

Date:_____ Relationship:_____

**I approve of this asthma action plan. I give my permission for the school nurse and trained school personnel to follow this plan, administer medication(s), and contact my provider. I assume full responsibility for providing the school with the prescribed medications and delivery of monitoring devices. I give my permission for the school to share the above information with school staff that need to know. I do hereby give my consent for the release and exchange of information contained in the medical record of my child.**

_____ _____ _____ _____

**Parent's Signature** **Phone Number** **Work Number** **Date**