**Alvarado ISD – School Health Services­­­­­­­­­­­­­­­­­­­­**

**Asthma Health Care Action Plan**

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ School Year/Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **Severity Classification** | **Triggers** | **Exercise** |
|  Intermittent  Moderate Persistent Mild Persistent  Severe Persistent |  Colds  Smoke Weather Exercise  Dust Animals  Food Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **1.** Premedication (how much/when)\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. Exercise modifications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Controller Medicines** | **How Much** | **How Often** | **Other Instructions** |
|  |  | \_\_\_\_\_times per day**EVERY DAY!** |  |
|  |  | \_\_\_\_\_times per day**EVERY DAY!** |  |
|  |  | \_\_\_\_\_times per day**EVERY DAY!** |  |
|  |  | \_\_\_\_\_times per day**EVERY DAY!** |  |
| **Quick-Relief Medicines** | **How Much** | **How Often** | **Other Instructions** |
| * Albuterol (Pro-air, Ventolin, Proventil)
* Levalbuterol (Xopenex)
 |  2 Puffs 4 Puffs 1Nebulizer Treatment | Take only as needed(See below starting in Yellow Zone or before exercise) | **Note:** If you need this medication more than two days a week, call physician to consider increasing controller medications and discuss treatment plan. |

**Symptoms:**

• Breathing is good

• No cough, wheeze, chest tightness, or shortness of breath

 during day or night

• Can do usual activities

**Peak Flow Meter**

More than 80% of personal best or \_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Green Zone:** Doing Well **Peak Flow Meter Personal Best =** |
| ***PREVENT*** asthma symptoms every day: Take controller medicines (above) every day Take medication before exercise if indicated (above) Avoid Triggers (above) |
| **Yellow Zone:** Getting Worse **Contact physician if using quick relief more than 2 times a week.*****CAUTION.*** Continue taking every day controller medicines, AND Take \_\_\_ puffs or \_\_\_\_ nebulizer treatment of quick relief medicine. If not back in Green Zone within \_\_\_\_\_\_\_\_ minutes take \_\_\_\_\_\_ more puffs or nebulizer treatments. If not back in the Green Zone within one hour, then: Increase \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Add \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Call \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Continue using quick relief medication every 4 hours as needed.  Call provider if not improving in \_\_\_\_\_\_ days.**Symptoms:**• Some breathing problems• Cough, wheeze, chest tightness, shortness of breath, or• Waking at night due to asthma symptoms, or• Can do some, but not all, usual activities**Peak Flow Meter**Between 50% and 80% of personal best or\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| **Red Zone:** ***Medical Alert******MEDICAL ALERT – Get Help*** Take quick relief medicine \_\_\_\_ puffs every \_\_\_\_\_ minutes.**Go to HOSPITAL or call for an AMBULANCE if:** Still in red Zone after 15 minutes. You have been unable to reach your physician for help.**Call an AMBULANCE-911 *IMMEDIATLEY* if :** Trouble walking/talking due to shortness of breath. Lips or fingernails are blue. If skin is sucked in around neck and ribs during breaths. Unresponsive**Symptoms:**• Lots of breathing problems• Very short of breath• Quick relief medicine is not helping• Cannot do usual activities• Symptoms betting worse instead of better**Peak Flow Meter**Less than 50% of personal best or\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Source: 2008 American Lung Association |

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**Physician Signature/Stamp Date Office Number**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Signature Date Contact Number**

**Alvarado ISD – School Health Services­­­­­­­­­­­­­­­­­­­­**

**Asthma Health Care Action Plan**

**Inhaler Authorization**

Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_ School Year/Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ needs to carry the following prescription labeled inhaler with him/her. The above named student has been instructed in the proper use of such inhaler and fully understands how to administer this medication. (It is preferable that another prescription labeled inhaler be kept in the clinic in case the fist is lost or left at home.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Dosage and Directions

**I have completed an asthma action plan for this student to have on file in the school nurse’s office. (Back of this form)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature/Stamp Date Office Number**

I have been instructed in the proper use of my prescription labeled inhaler and fully understand how to administer this medication. I will not allow another student to use my prescription labeled inhaler under any circumstances. I also understand that should another student use my prescription labeled inhaler, the privilege of carrying it with me may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of the use of my inhaler in case I start having problems with my asthma.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Signature Date**

I hereby request that the above named student, be allowed to carry his/her prescription labeled inhaler described above on the AISD campus(es), and be responsible for its use as needed. I understand that the parent/guardian accepts the legal responsibility should the above inhaler be lost, given, or taken by a person other than the student for whom it was prescribed. It this should happen, the privilege of carrying the inhaler may be revoked. I understand that AISD has no legal responsibility when the above named student administers his/her own medication.

I give permission for the information contained on the HCAP to be shared with adults in the school setting that will be working with my child on a need-to-know basis. This HCAP will remain in effect for one year or until the health status or physicians orders change. It is the responsibility of the parent/guardian to notify the school nurse whenever this is any change in the student’s health status or care.

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**Parent/Guardian Signature Date Contact Number**