HOUSTON INDEPENDENT SCHOOL DISTRICT
HATTIE MAE WHITE EDUCATIONAL SUPPORT CENTER
4400 WEST 18th STREET • HOUSTON, TEXAS 77092-8501

www.houstonisd.org
www.twitter.com/HoustonISD

Asthma Action Plan
Parent Letter

Date: _____

Dear Parent/Guardian of: _____ _____:

Good control of your child's asthma is important to his or her success at school. A talk between you and your child, your doctor and school staff is the key to controlling asthma at school. An Asthma Action Plan completed by your doctor and shared with the school will help keep your child safe. Following the Asthma Action Plan will help your child to be a part of all school activities.

If your child has an Asthma Action Plan, please send a copy to the school nurse. If your child does not have an Asthma Action Plan, please talk with your doctor about making one that can be shared with the school staff. It can be faxed (directly) to the school nurse at fax number 713 867 5151.

Attached is an Asthma Action Plan that should be filled out by your doctor.

- ☑ Please bring your medication to the school nurse.
- ☑ Please bring your completed Asthma Action Plan.

If you have any questions, you may call me at 713.867.5150.

Thank you

School Nurse KAcosta Principal _____

Telephone 713.867.5150

email address elva.acosta@houstonisd.org

website

Asthma Action Plan

Student's Name_____ Grade_____ Date of Birth:_____ School_____

Inhaler kept in_____ ❑ School clinic ❑ Self-carry

ACTION CONTROL PLAN

Level of Severity ❑ Intermittent ❑ Mild Intermittent ❑ Moderate ❑ Persistent ❑ Severe Persistent ❑ High Risk

Control ❑ Well controlled ❑ Not well controlled ❑ Very poorly Controlled

Triggers ❑ Animals ❑ Pollen ❑ Dust Mites ❑ Viral Respiratory Infections ❑ Mold ❑ Exercise ❑ Weather ❑ Smoke ❑ Other

Allergies _____

Pulse Ox

❑ ≥ 95% normal

❑ Other_____

If student has any of the following symptoms – chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath you will do this: Stop activity and help student to a sitting position, stay calm, reassure student, assist student with use of inhaler if they self-carry, escort student to school clinic or call for nurse for immediate assistance. Never send student to clinic alone!!!

GREEN ZONE – DOING WELL

- Breathing is normal
- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than_____ (80 percent or more of best peak flow)

Take these long-term control medicines each day.

Controller Medications	How much to take	When to take it	At School
_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	❑ Yes ❑ No
❑ **Rescue** Medications	❑ 2 or ❑ 4 puffs ❑ 6 puffs	❑ 10 – 20 minutes before exercise	❑ Yes ❑ No
_____	❑ PRN_____hrs	_____	

YELLOW ZONE – ASTHMA IS GETTING WORSE

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

If pulse Oximeter is used 02 Sat

_____% to_____%

First **Add: rescue medicine**

_____ ❑ 2 or ❑ 4 ❑ 6 puffs, every _____ Minutes Repeat every _____Minutes for up to 1 hour

(short-acting beta2-agonist) ❑ Nebulizer solution_____Repeat every_____Minutes

Second **If symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

❑ Continue monitoring to be sure student stays in the GREEN ZONE

-Or-

If symptoms (and or pulse Ox, if used) do not return to GREEN ZONE after 1 hour of above treatment move to RED ZONE.

RED ZONE – MEDICAL ALERT! DANGER

- Very short of breath, or
- Rescue medicines have not helped,
- Cannot do usual activities, or
- Symptoms are same or get worse after treatment in Yellow Zone Pulse Oximeter < 93%

First **Rescue medicine**

❑_____ ❑ 4 or ❑ 6 puffs every _____Minutes or Nebulizer Solution every_____Minutes

(short-acting beta2-agonist)

Second **Call 911 if unable to return action to yellow zone after 15 minutes or less, call 911, and parent/guardian.**

EMERGENCY! ■ Trouble walking and talking due to shortness of breath ■ Lips or fingernails are blue ■ Chest or neck is pulling in while breathing ■ Student must bend forward to breathe

Self Administration ■❑ By checking this box and signing below, health care provider and parent, give written authorization of permission for this student to self carry and self administer prescription asthma medication during school or at school related events. This includes authorization to coach and discuss this condition and elements of care with health care provider indicated on this form

Date_____Provider Signature_____Provider Printed Name_____Provider Phone_____Fax _____

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate.
I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor, and for asthma management and administration of this medication.

Date_____Parent/guardian signature_____Home phone/cell_____Work_____Alternate contact number_____

Nurse Signature:_____Nurse Name:_____Office Phone:_____Fax:_____

How To Control Things That Make Your Asthma Worse

This guide suggests things you can do to avoid your asthma triggers. Put a check next to the triggers that you know make your asthma worse and ask your doctor to help you find out if you have other triggers as well. Then decide with your doctor what steps you will take.

Allergens

☐ Animal Dander

Some people are allergic to the flakes of skin or dried saliva from animals with fur or feathers.

The best thing to do:

- Keep furred or feathered pets out of your home.

If you can't keep the pet outdoors, then:

- Keep the pet out of your bedroom and other sleeping areas at all times, and keep the door closed.
- Remove carpets and furniture covered with cloth from your home. If that is not possible, keep the pet away from fabric-covered furniture and carpets.

☐ Dust Mites

Many people with asthma are allergic to dust mites. Dust mites are tiny bugs that are found in every home—in mattresses, pillows, carpets, upholstered furniture, bedcovers, clothes, stuffed toys, and fabric or other fabric-covered items.

Things that can help:

- Encase your mattress in a special dust-proof cover.
- Encase your pillow in a special dust-proof cover or wash the pillow each week in hot water. Water must be hotter than 130° F to kill the mites. Cold or warm water used with detergent and bleach can also be effective.
- Wash the sheets and blankets on your bed each week in hot water.
- Reduce indoor humidity to below 60 percent (ideally between 30—50 percent). Dehumidifiers or central air conditioners can do this.
- Try not to sleep or lie on cloth-covered cushions.
- Remove carpets from your bedroom and those laid on concrete, if you can.
- Keep stuffed toys out of the bed or wash the toys weekly in hot water or cooler water with detergent and bleach.

☐ Cockroaches

Many people with asthma are allergic to the dried droppings and remains of cockroaches.

The best thing to do:

- Keep food and garbage in closed containers. Never leave food out.
- Use poison baits, powders, gels, or paste (for example, boric acid). You can also use traps.
- If a spray is used to kill roaches, stay out of the room until the odor goes away.

☐ Indoor Mold

- Fix leaky faucets, pipes, or other sources of water that have mold around them.
- Clean moldy surfaces with a cleaner that has bleach in it.

☐ Pollen and Outdoor Mold

What to do during your allergy season (when pollen or mold spore counts are high):

- Try to keep your windows closed.
- Stay indoors with windows closed from late morning to afternoon, if you can. Pollen and some mold spore counts are highest at that time.
- Ask your doctor whether you need to take or increase anti-inflammatory medicine before your allergy season starts.

Irritants

☐ Tobacco Smoke

- If you smoke, ask your doctor for ways to help you quit. Ask family members to quit smoking, too.
- Do not allow smoking in your home or car.

☐ Smoke, Strong Odors, and Sprays

- If possible, do not use a wood-burning stove, kerosene heater, or fireplace.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

Other things that bring on asthma symptoms in some people include:

☐ Vacuum Cleaning

- Try to get someone else to vacuum for you once or twice a week, if you can. Stay out of rooms while they are being vacuumed and for a short while afterward.
- If you vacuum, use a dust mask (from a hardware store), a double-layered or microfilter vacuum cleaner bag, or a vacuum cleaner with a HEPA filter.

☐ Other Things That Can Make Asthma Worse

- Sulfites in foods and beverages: Do not drink beer or wine or eat dried fruit, processed potatoes, or shrimp if they cause asthma symptoms.
- Cold air: Cover your nose and mouth with a scarf on cold or windy days.
- Other medicines: Tell your doctor about all the medicines you take. Include cold medicines, aspirin, vitamins and other supplements, and nonselective beta-blockers (including those in eye drops).

U.S. Department of Health and Human Services
National Institutes of Health

National Heart Lung and Blood Institute

For More Information, go to: www.nhlbi.nih.gov

NIH Publication No. 07-5251
April 2007

Houston Independent School District
Health and Medical Services

REQUEST FOR ADMINISTRATION OF MEDICATION AT SCHOOL

This form must be filled out completely to allow the School Nurse and /or other trained staff assigned by the Principal to administer medication to a student. A new medication form must be completed at the beginning of each school year for each prescription medication, and each time there is a change in the medication's administration instructions.

In accordance with district policy, only prescription medication will be administered.

- Prescription medication must be delivered to school in its original container.
- The container must be properly labeled by a pharmacist.

Student's Name _____ Sex_____

Date of Birth _____ / _____ / _____ Name of School _____

Medical Diagnosis: _____ ☐Infectious ☐Non-Infectious ☐Allergy

Medication Name: _____

Dose (amount to be given): _____

Frequency (how often): _____

Form of Medication (Route): _____

☐tablet ☐pill ☐capsule ☐liquid ☐inhalation ☐injection

☐ other (specify): _____

Possible side effects _____

Special requirements for administration / storage _____

Known food allergies YES NO If Yes, please explain _____

This is permission to give medication to my child named above as requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone

_____
Date

_____
Physician's/Advanced Practice Nurse Signature

_____
Physician's/Advanced Practice Nurse Name (print or type)

_____
Date

_____
Facility Name

_____
Telephone

Houston Independent School District
Health and Medical Services

Policies Governing Self -Administration of Emergency Medication for Treatment of Asthma, Anaphylaxis and Diabetes while on School Property or a School Related Activity

District policy allows a student at risk for anaphylaxis or a diagnosis of asthma, or diabetes to possess and self-administer prescription medicine for management of their care under certain conditions.
This form must be filled out completely to allow students with these conditions to possess and self-administer prescription medicine. A new medication form must be completed at the beginning of each school year for each prescription medication, and each time there is a change in the medication's administration instructions.
It is important to note the following:

- By signing below, the health care provider and parent confirms that the student is capable of self-administration of the medication.
- The School Nurse may re-evaluate the student's ability to self-administer medications as needed
- Self-administration orders must be included in the Diabetes Medical Management Plan (DMMP) for students with diabetes.
- This serves as an exception to the HISD medication policy that requires all medications to be kept in a locked area in the nurse's office.

Student's Name _____ Sex_____

Date of Birth ____ / ____ / ____ Name of School _____

Medical Diagnosis: _____ ☐Infectious ☐Non-Infectious ☐Allergy

Medication Name: _____

Dose (amount to be given): _____

Frequency (how often): _____

Form of Medication (Route): _____

☐tablet ☐pill ☐capsule ☐liquid ☐inhalation ☐injection

☐ other (specify): _____

Possible side effects _____

Student has demonstrated that they can self-administer their medication Yes No

If NO, please explain other support needed to achieve independence _____

This is permission for my child named above to self-carry medication requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone:

_____
Date:

_____
Physician's/Advanced Practice Nurse Signature

_____
Physician's/Advanced Practice Nurse Name (print or type)

_____
Date

_____
Facility Name

_____
Telephone