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

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# Plan de Acción en Caso de Asma
# Carta para los padres

Fecha: _____

Estimado padre o tutor de _____:

Para que su hijo tenga éxito en la escuela, es necesario que mantenga el asma bajo control. Es muy importante que usted y su hijo conversen con su médico y con el personal escolar para saber cómo controlar el asma en la escuela. Si su doctor le da un Plan de Acción en Caso de Asma y usted lo comparte con nosotros, su hijo estará más seguro y podrá ser parte de todas las actividades escolares.

Si su hijo ya tiene un Plan de Acción en Caso de Asma, por favor envíele una copia a la enfermera de la escuela. Si no lo tiene, hable con su médico para que le cree uno y pueda usted compartirlo con el personal escolar. Envíelo por fax, directamente a la enfermera de la escuela, al número 713. 867. 5751.

Adjunto le enviamos un formulario del Plan de Acción en Caso de Asma, mismo que su médico debe llenar.

☑ Favor de entregarle sus medicamentos a la enfermera de la escuela.

☑ Por favor llene y traiga el Plan de Acción en Caso de Asma

Si tiene alguna pregunta, puede llamarme al 713. 867. 5750.

Gracias

Enfermera de la Escuela K. Acosta  Director _____

Teléfono 713. 867. 5750

Dirección de correo electrónico elva. acosta@ houstonisd. org

Sitio web

# 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:_____

# 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