McKinney Independent School District
Asthma Action Plan-(To be signed by physician within 10 days)

photo

Name of Student: _____ Date of Request: _____

Date of Birth: _____ Grade: _____ Homeroom Teacher: _____

According to the *NIH Asthma Management Guidelines*, this student's asthma is

( ) Mild intermittent ( ) Moderate persistent ( ) Mild persistent ( ) Severe persistent

I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

This student's specific signs and symptoms of an asthma attack include: _____

Name, dose, and frequency of **preventive** medications used at home _____

GREEN ZONE – GO ZONE!

(Use preventive medicine.)

- Breathing is good.
- No cough or wheeze
- Sleeps through night
- Can work or play
- *Or peak flow _____ to*

1. This patient has Exercise-Induced Asthma? ( ) YES ( ) NO
   If yes, what medication should be given for EIA? Exp. Date____

Use the indicated treatment below 15-20 minutes before exercise as needed:

_____

_____

YELLOW ZONE – CAUTION ZONE!

(Add fast-acting medication.)

- First signs of a cold
- Exposure to a known trigger
- Mild coughing or wheezing
- Chest tightness
- Shortness of breath
- *Or peak flow __to ___*

Yellow Zone

1. For acute/exacerbated asthma what medication(s) dosage and times) should be used?

Inhaler(exp date_____)

_____

_____

Or

Nebulizer(exp. date _____)

_____

RED ZONE – DANGER ZONE!

(Get help from a doctor.)

- Medicine isn't helping.
- Breathing is hard and fast
- Nostrils flare wide open
- Ribs show during breathing
- Can't talk without stopping frequently to breathe
- Wheeze with inhale & exhale
- *Or peak flow ___ to ___*

1. For worsening asthma signs, what fast-acting medication should be used? **Use the indicated treatment every 20 min. as needed up to three times and monitor student.** If symptoms do not improve or student condition worsens with treatment above get **immediate** medical attention—Call 911 if legal guardian is unavailable.

_____

_____

_____

_____

_____

_____

I certify that the above named student has a reactive airway disease and is capable of carrying and self-administering the above fast-acting medication(s) after complying with the school district's regulations. **Must also complete self carry form.**

( ) YES ( ) NO

Physician's Printed Name: _____ Signature: _____ Date: _____

Physician's Telephone Number: _____ FAX Number: _____

I give permission to the school nurse, and other designated staff members of McKinney ISD to perform and carry out the asthma care tasks as outlined in this Asthma Action Plan. I understand that if at any time the supervising adult believes my child's life is in danger, Emergency Medical Services (911) will be activated, and I agree that my insurance carrier or I will assume the responsibility for all costs incurred as a result. I understand that the School District, Board of Trustees, and District employees shall not be held responsible for damages or injuries resulting from administration of this medication.

I consent to the release of medical information contained on this form to school officials who have a legitimate educational interest in the information, according to MISD Board Policy and the Family Education and Privacy act. I give permission for the release of confidential information regarding my child's specific health problems to third parties, other than school officials, as required to facilitate medical care and/or treatment of my child. I authorize the nurse and the prescribing physician to confidentially discuss or clarify this medication order and to discuss the student's response to the prescribed medication as needed per law (Nurse Practice and Medical Practice Acts of Texas).

Parent's Printed Name: _____ Signature: _____ Date: _____

Daytime Phone: _____ Parent's E-mail: _____