



# Ysleta Independent School District

## Student Health Services

### Student Asthma Action Plan

Name/ Nombre: _____ Homeroom Teacher/ Maestro: _____ Parent/Guardian/ Padre o Guardian: Name/ Nombre: _____ Address/ Dirreccion: _____ Parent/Guardian/ Padre o Guardian: Name/ Nombre: _____ Address/ Dirreccion: _____ Emergency Phone Contact #1/ Contacto de Emergencia #1 _____ Emergency Phone Contact #2/ Contacto de Emergencia #2 _____	Grade/ Grado: _____ Room/ Cuarto: _____ Ph: (H)/ Tel (casa): _____ Ph: (W)/ Tel(Trabajo): _____ Ph: (H)/ Tel (casa): _____ Ph: (W)/ Tel(Trabajo): _____	Age/ Edad: _____ <div style="border: 1px solid black; padding: 20px; text-align: center; width: 100px; margin: 0 auto;">           Student Picture Here         </div>
Name/Nombre	Relationship/Parentesco	Phone/Teléfono
Name/Nombre	Relationship/Parentesco	Phone/Teléfono

## TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER

Physician Treating Student for Asthma \_\_\_\_\_ Ph: \_\_\_\_\_

Other Physician \_\_\_\_\_ Ph: \_\_\_\_\_

### My Personal Asthma Triggers

**Identify the things which start an asthma episode (Check each that applies to the student.)**

- |   |                                     |  |
|---|-------------------------------------|--|
| <input type="checkbox"/> Exercise               | <input type="checkbox"/> Chalk Dust | <input type="checkbox"/> Food _____    |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Carpets    | <input type="checkbox"/> Animals _____ |
| <input type="checkbox"/> Change in temperature  | <input type="checkbox"/> Smoke      | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Strong odors or fumes  | <input type="checkbox"/> Pollens    | _____                                  |
| <input type="checkbox"/> Dust                   | <input type="checkbox"/> Mold       | _____                                  |

### Peak Flow Monitoring

**INSTRUCTIONS:** This plan is divided into 3 zones, green, yellow, and red, similar to the colors of a traffic light.

If you are in the **GREEN** zone, then you're doing well. You probably don't need to do anything other than take your daily medicines as prescribed.

If you are in the **YELLOW** zone, it means you are getting a warning. Yellow means that your asthma may be getting worse and you are probably having a flare up. Action is needed to prevent an asthma attack.

If you are in the **RED** zone you are in danger, and you **MUST** take emergency action, as described on the plan, right away!

**Personal Best Peak Flow Number:** \_\_\_\_\_

**GREEN ZONE**

- Breathing is good
- No cough or wheeze
- Sleep through night
- Can work and play

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**PEAK FLOW FROM \_\_\_\_\_ TO \_\_\_\_\_**

1. What preventative medications are prescribed and how often are they given?  
Name and Dose:  
\_\_\_\_\_  
\_\_\_\_\_

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2. Does this patient have Exercise Induced Asthma? Yes No

**YELLOW ZONE**

- First signs of a cold
- Exposure to know trigger
- Coughing doesn't stop
- Mild wheeze
- Chest tightness

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**PEAK FLOW FROM \_\_\_\_\_ TO \_\_\_\_\_**

In case of an asthma exacerbation, what quick-relief medication should be used?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**RED ZONE**

- Medicine isn't helping
- Breathing is hard and fast
- Nose opens wide
- Ribs show during breathing
- Can't talk well
- Inhale & exhale wheeze**

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**PEAK FLOW BELOW \_\_\_\_\_**  
nurse. Or, call 911

1. In case of an asthma exacerbation, what quick-relief medication should be used?  
\_\_\_\_\_  
\_\_\_\_\_

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2. Get immediate medical attention – Call your doctor. If at school, go to the nurse. Or, call 911

# Emergency Plan

Emergency Action is necessary when the student has symptoms such as:

1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_
  4. \_\_\_\_\_
- or has a peak flow reading of \_\_\_\_\_

## Steps to take during an asthma episode:

1. Check peak flow.
2. Give emergency medications:
  - A. Bronchodilator (Quick-relief medication):

Name: \_\_\_\_\_

Purpose: \_\_\_\_\_

Dosage: \_\_\_\_\_ When to use: \_\_\_\_\_

Can be repeated for severe breathing difficulty \_\_\_\_\_ times \_\_\_\_\_ minutes apart.

**Call 911 or EMS if minimal or no improvement**

- B. Other Medications:

Name: \_\_\_\_\_

Purpose: \_\_\_\_\_

Dosage: \_\_\_\_\_ When to use: \_\_\_\_\_

Additional Instructions: \_\_\_\_\_

These medications are prescribed for the time period \_\_\_\_\_ until \_\_\_\_\_

### 3. Seek emergency medical care if this student experiences any of the following:

- ◆ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
- ◆ Student exhibits:
  - Chest and neck pulled in with breathing
  - Struggling to breathe
  - Stops playing and cannot start activity again
  - Hunched over while breathing
  - Trouble walking or talking
  - Lips or fingernails turn gray or blue

## Comments / Special Instructions

- Yes I, the signed physician, certify that the student has asthma and is capable of carrying and self-administering the above quick-relief asthma medication.
- No

Physician's Signature \_\_\_\_\_

Date \_\_\_\_\_

The school nurse has the responsibility to assess the skill level necessary of all students who self-administer their prescription medication for asthma or anaphylaxis, including the use of any device required to administer the medication (Education Code, Section 38.013, YISD Policy FFAC Legal). *La enfermera escolar tiene la responsabilidad de evaluar el nivel de habilidad del estudiante para administrar su prescripción médica para asthma o anafilactico, inclusive el uso de cualquier aparato para administrar ese medicamento.*

I give permission to my child's school to administer daily and emergency medications as necessary, in accordance with physician's instructions above. Doy mi permiso para que la escuela de mi hijo/a le dé el/los medicamento(s) necesario diariamente o de emergencia de acuerdo con las instrucciones del médico indicado en la primera parte de esta forma.

\_\_\_\_\_  
Parent/Guardian's Signature/Firma de Padre o Guardian

\_\_\_\_\_  
Date/Fecha