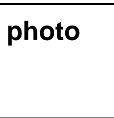

McKinney Independent School District
Asthma Action Plan-(To be signed by physician within 10 days)

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 below 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 MISD Inhaler Self-Administration 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: __________________________________

Asthma Medication Documentation

Student's Name: ____

Medications and Dosages : (A) ____________________________ Admin. Time(s): _________

(B) ____________________________ Admin. Time(s): _________

(C) ____________________________ Admin. Time(s): _________

Signatures & Initials: ____________________________ ________ ____________________________ ________

____________________________ ________ ____________________________ ________

____________________________ ________ ____________________________ ________

____________________________ ________ ____________________________ ________

Date Given	Med Given A, B, or C	Time	Signature	Date Given	Med Given A, B, or C	Time	Signature

Medication _________________picked up by parent ___________________________________ ______________

Parent Signature Date

Medication _________________picked up by parent ___________________________________ ______________

Parent Signature Date

Medication _________________picked up by parent ___________________________________ ______________

Parent Signature Date

The following medication was destroyed due to failure to pick up the medication prior to the last day of school or expiration of date medication was discontinued:

Amount of medication disposed of: ____

RN Signature: ____ Witness Signature: ___________________________________

Date: ____ Time: ____

Attach Photo

Health Condition Information Sheet
(For general staff use, copy and distribute as needed)

Student's Name ______________________________ D.O.B. ________________

Condition ______________________________ Grade ________________

Physician's Name ______________________________ Phone # ________________

Parent's Name(s) ______________________________ Home Phone # ________________

Street Address ______________________________ Work Phone # ________________

Employer ______________________________ Cell/Mobile # ________________

Emergency Contact #1 ______________________________ Phone # ________________

Emergency Contact #2 ______________________________ Phone # ________________

If signs or symptoms of the above condition are noted please take the following steps:

A) If this happens: ______________________________

Then do this: ______________________________

B) If this happens: ______________________________

Then do this: ______________________________

C) If this happens: ______________________________

Then do this: ______________________________

Please circle one of the following to indicate the level at which this student can perform this care.

Independently Needs Assistance/Supervision Cannot do for self

Additional Comments: ______________________________

____

____

____

The IHP has been reviewed and discussed by the school nurse &/or parent/guardian & have listed the above information as staff awareness and individualized student information to expedite the care of the student during times when a school nurse may not be readily available. **This form may also be completed by the campus RN when information from the physician or parent has not been received and a teacher/substitute teacher needs to be advised of a medical condition & steps to ensure safety during times when a school nurse may not be readily available.**

School RN's Printed Name: ________________ Signature: ________________ Date: ________

Optional Parent Printed Name: ________________ Signature: ________________ Date: ________

Optional MD Printed Name: ________________ Signature: ________________ Date: ________