

McKinney Independent School District  
School Health Services

Attach  
Photo

**Asthma Action Plan (Must be signed by physician within 10 days)**

Name of Student: \_\_\_\_\_ Date of Request: \_\_\_\_\_ ID: \_\_\_\_\_

DOB: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_ Inhaler Exp. date \_\_\_\_\_

**NEBULIZER TREATMENTS WILL NOT BE ADMINISTERED IN SCHOOL WHILE COVID-19 RESTRICTIONS IN PLACE**

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

Mild intermittent

Moderate persistent

Mild persistent

Severe persistent

The student's specific signs and symptoms of an asthma attack include: \_\_\_\_\_

Name, Dose, Frequency of Long Acting Medication given at home: \_\_\_\_\_

**Green Zone at School: Go Zone**

\* Breathing is good \* No cough or wheeze \* Sleeps through night \* Can work or play

Does student have Exercise Induced Asthma (EIA)?  Yes  No

Quick Acting Medication for EIA: Albuterol/Levalbuterol \_\_\_\_\_ puffs 15 minutes before activity as needed

**Yellow Zone at School: Caution Zone**

\* First signs of a cold \* Exposure to a known trigger \* Mild coughing or wheezing \* Chest tightness \* Shortness of breath

Quick Acting Medication: Albuterol/Levalbuterol \_\_\_\_\_ puffs every \_\_\_\_\_ hours as needed

**Red Zone at School: Danger Zone**

\* Medication is not helping \* Breathing hard & fast \* Nostrils flaring \* Difficulty talking \* Wheezing with inhale & exhale

Quick Acting Medication: Albuterol/Levalbuterol \_\_\_\_\_ puffs every 20 minutes as needed up to three times and monitor student. If symptoms do not improve or student's condition worsens with treatments, 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 regulation. **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 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: \_\_\_\_\_

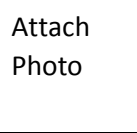
Daytime Phone Number: \_\_\_\_\_ Parent's Email: \_\_\_\_\_

The following medication was destroyed due to failure to pick up the medication prior to the last day of school, medication was discontinued or medication was discontinued or medication was picked up by parent:

Medication(s) name & amount dispensed \_\_\_\_\_ Time \_\_\_\_\_ Date \_\_\_\_\_

RN Signature: \_\_\_\_\_ Witness Signature: \_\_\_\_\_

Medication(s) name & amount picked up \_\_\_\_\_ Parent signature & Date \_\_\_\_\_



**Health Condition Information Sheet**

(For general staff use, copy and distribute as needed)

Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ ID \_\_\_\_\_

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: \_\_\_\_\_