Attach Photo

McKinney Independent School District
School Health Services

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**_____

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 _____

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McKinney Independent School District
School Health Services

Health Condition Information Sheet

(HEALTH SERVICES USE ONLY)

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: _____