Plano Independent School District

District Health Services

School Asthma Action Plan

School Year: _____

Name: _____DOB: _____ID#: _____
Grade/Teacher/Section: _____ Bus#: _____

Place Student Picture here

Daily Asthma Treatment and Emergency Plan

Medical Equipment

Please list any medical equipment this student will need to treat his/her asthma at school (i.e. spacer, nebulizer supplies, oxygen, etc.) Parent will provide all equipment and supplies needed: _____

_____

_____

Green Zone – Peak Flow(PF) Range: _____ to: _____ (PF 80-100% of personal best) ***No Symptoms***

☐ No control medications required **OR**

☐ Oral control medication: _____ Taken: _____ times/day

☐ Puff(s) of: _____ MDI/HFA Taken: _____ times/day

☐ Nebulizer treatment with: _____ Taken: _____ times/day

For asthma symptoms with exercise: _____ puff(s) of: _____ 15 minutes before exercise.

Yellow Zone – Peak Flow (PF) Range: _____ to: _____ (PF between 50-80% of personal best).

Tight chest, cough, mild wheeze, signs of upper respiratory illness, unable to exercise.

☐ Puff(s) of: _____ MDI/HFA Taken: _____ times/day

☐ Nebulizer treatment with: _____ Taken: _____ times/day

Red Zone – Peak Flow below: _____ (PF less than 50% of personal best)

EMERGENCY ACTION IS NECESSARY WHEN STUDENT HAS SYMPTOMS SUCH AS:

Can't talk, eat or walk well **Medication is not working** **Chest/neck retractions**

Breathing hard and fast **Blue lips and/or fingernails** **PO_2 less than: _____%**

☐ **Puff(s): _____ MDI/HFA every: _____ minutes for three (3) treatments OR**

☐ **Nebulizer treatment with: _____ every: _____ minutes for three (3) treatments**

Physician's Consent for Self-Administration of Asthma Medication

I have instructed the above student in the proper way to use the asthma medication. It is my professional opinion that this student SHOULD: ☐ SHOULD NOT: ☐ (CHECK ONE) be allowed to carry and self-administer his/her asthma medications while on school property or at school related events. **Physician's Initials: _____**

Physician's Signature:_____Date: _____

Physician's Printed Name:_____Telephone: _____

Parent / Guardian Consent – Asthma

Name:_____ DOB:_____ ID#:_____ SY: _____

Emergency Contacts

Name	Telephone Number	Relationship to Student

Background Information

Asthma Control: Well controlled: ☐ Needs better control: ☐

Has the student ever experienced a severe asthma episode in the past that required emergency room care or hospitalization? What care was needed at that time?

Asthma Severity

Asthma Severity	Check Here	Asthma Severity	Check Here
Mild:	☐	Persistent:	☐
		Mild Persistent:	☐
		Moderate Persistent:	☐
		Severe Persistent:	☐

Asthma Triggers

Asthma Trigger:	Check Here	Asthma Trigger:	Check Here	Asthma Trigger:	Check Here
Colds	☐	Pollen	☐	Dust	☐
Animals:	☐	Smoke	☐	Stress	☐
Pests(rodents, roaches)	☐	Exercise	☐	Gastroesophageal reflux	☐
Strong Odors	☐	Seasonal	☐	Other:	☐

Parent/Guardian Consent for Self-Administration of Asthma Medication

I **DO:** ☐ **DO NOT:** ☐ **(check one)** give consent for my child to carry and self-administer his/her asthma medications. If my child caries his/her own asthma medication, I realize that the school clinic will not have his/her personal asthma medication(s) unless I supply the school with an extra one in case my child forgets his/hers. I understand that the school nurse will also assess my child's knowledge and ability to identify symptoms and self-administer his/her asthma medication(s). However, I acknowledge that the school is relying on my representation that my child is adequately trained to identify symptoms and self-administer his/her asthma medication(s).

Parent Initials: _____

Parent/Guardian Consent for Unlicensed Assistive Personnel to Administer Asthma Medication

I **DO:** ☐ **DO NOT:** ☐ **(check one)** authorize the District to designate unlicensed assistive personnel (UAP) who have been trained by a medical professional, including but not limited to, emergency medical personnel, a physician and/or a registered nurse to administer asthma medication(s) to my child while in attendance at Plano ISD or Plano ISD related events (such as field trips and athletic events), when a trained medical professional may not be available. I

understand that school related health services may not be provided to my student without my required consent, as outlined herein. **Parent Initials: _____**

Parent/Guardian Consent to Share Information and Picture

I **DO: ☐ DO NOT: ☐ (check one)** authorize Plano ISD to display a picture of my child and identify that this is a person with asthma. I understand that school staff that comes into contact with my child will be given information about my child that would assist them in an emergency situation. This may include but is not limited to: health office staff and substitutes, classroom teachers and aides, special subject teachers, substitute teachers, office staff, cafeteria staff and bus drivers. I understand that the reason for this is to enable school personnel to better prevent and respond to potential emergencies. This authorization is valid from the date signed for the remainder of the current school year.
Parent Initials: _____

Parent/Guardian Authorization for School Staff to Communicate Health Information

I authorize the District's designees, including District medical professionals and U!Ps, to share/obtain my student's health related information with the medical health professional or health care provider identified above to plan, implement or clarify actions necessary in the administration of school related health services such as but not limited to: emergency care, care for any documented diagnosis, medical treatments as outlined in a student's IHP, 504 plan, IEP, or other PISD form requesting for school health care services. By signing this Authorization, I readily acknowledge that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by designees authorized herein and the person(s) with whom they communicate, and no longer be protected by the HIPAA rules. I realize that such re-disclosure might be improper, cause me embarrassment, cause family strife, be misinterpreted by non-health care professionals, and otherwise cause me and my family various forms of injury. I hereby release any HealthCare Provider that acts in reliance on this Authorization from any liability that may accrue from releasing my child's Individually Identifiable Health Information. School-related health services described herein shall not be provided to a student without the required consent of the parent/guardian, as outlined herein. **Parent Initials: _____**

Parent/Guardian Release of Claims Against District and Agreement to Indemnify

To the extent permitted under the law, on behalf of myself and the student, I release and agree to defend, indemnify, and hold harmless the District for all claims, damages, demands, or actions arising from, relating to or growing out of, directly or indirectly, the administration of Asthma Medication to the Student, the Student's self-administration of Asthma Medication and/or the disclosure of Individually Identifiable Health Information. This release is to be construed as broadly as possible. It includes a release of claims against the District for its, joint or singular, sole or contributory, negligence or strict liability, including liability arising from the alleged violation of any statute (other than those which protect against discrimination based on race, age, sex, or other classification which has experienced historical discrimination), growing out of, relating to, or arising out of, directly or indirectly, the School Staff's administration of Asthma Medication to the student and/or Student's self -administration of Asthma Medication, or the disclosure of Individually Identifiable Health Information, including but not limited to claims that School Staff failed to properly and sufficiently assess my child's knowledge and ability to identify symptoms and self-administer his/her asthma medication(s), negligently failed to recognize symptoms requiring the use of Asthma Medication, misconstrued symptoms which it believed necessitated the use of Asthma Medication, negligently administered or failed to administer Asthma Medication(s), or "over-disclosed" my child's health information.
Parent Initials: _____

The School Health Administrative Guidelines developed by the Plano Independent School District are subject to the Americans with Disabilities Act ("!D!"), 42 U.S.C. §12101, et seq.- Section 504 of the Rehabilitation Act of 1973 ("Section504"), 29 U.S.C. § 701, et seq.- and the Individuals with Disabilities Education !ct ("IDE!"), 20 U.S.C. § 1400 et seq.

Parent / Guardian Signature: _____ Date: _____

Parent / Guardian Name: _____ Telephone: _____