Katy Independent School District

Asthma Action Plan

Transportation
□ Car Rider □ Walker
□ Bus #_____
□ Other: _____

Student has permission to transport medication listed below to and from school?
□ YES □ NO

Place Child's Picture Here

Patient's Name		DOB	Grade	Effective Date: / / to / /
Check Asthma	Mild Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent

Trigger List: (check all that apply)

	Chalk Dust		Cigarette Smoke		Colds/Flu		Wood Smoke
	Dust/Dust Mites		Stuffed Animals		Carpet		Strong Odors
	Exercise		Mold		Ozone Alert Days		Cleaning Products
	Pests		Pets		Plants, Flowers, Cut Grass & Pollen		Other:
	Sudden Temperature Changes		Perfume		Foods:		

Katy ISD staff will **administer medication(s)** as prescribed, **call 911 for severe symptoms that do not improve with medication, and notify parents** of action plan initiation.

GOOD CONTROL → Use these medications every day.

You have **all** of these:

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

Medication/Dosage	How Much to Take	When to take it	How Often

Comments:

For exercise, take:

CAUTION → Continue with daily medicine and ADD:

You have any of these:

- First sign of a cold
- Exposure to a known trigger
- Cough
- Mild wheeze
- Tight chest
- Cough at night
- Can do some but not all usual activities.
- Peak flow 50-80%.

Medication/Dosage	How Much to Take	When to take it	How Often

Comments:

If Quick Reliever/Yellow Zone medicines are used more than 2 to 3 times per week, CALL your Doctor

DANGER ZONE → Take these medicines and call your doctor.

Your asthma is getting worse fast:

- Medicine is not helping within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips blue
- Fingernails blue or gray
- Trouble walking or talking
- Coughs constantly
- Stiff/stooped posture
- Peak Flow below 50%

Medication/Dosage	How Much to Take	When to take it	How Often

Comments:

DO NOT WAIT! GET HELP FROM A DOCTOR NOW!
If you cannot contact your doctor, go directly to the emergency room.

I agree with the recommendations of my child's HCP and authorize Katy ISD staff to deliver treatment as outlined above. I also give permission for my child's HCP to communicate with appropriate Katy ISD employees for the current school year.

Physician Signature:	Printed Name:	Phone:	Date:
Parent Signature:	Printed Name:	Phone:	Date:

ADDENDUM to Action Plan

NURSE USE ONLY:

☐ Transportation Notified: Date Faxed _____

☐ Bus Driver Notified

☐ Added to Medical Alerts

☐ Self-Carry

☐ Diet Modification: Date Faxed _____

☐ RTI ☐ 504 ☐ ARD Committee Notified: Date _____

In addition: A full IHP needed for a 504 or an ARD

	Field Trips	Student will be grouped with a trained staff member.
	Before or After School Activities (i.e. Safety Patrol, Clubs, Sports)	Nurse and Parent will discuss a plan for their child.
	Emergency Evacuation of School	Nurse will bring medication/supplies out of building and will attend to student as needed.

◊ TRAINED STAFF MEMBERS ◊ (To be completed by campus personnel)	
Teacher's Name:	**Date:**
Teacher's Name:	**Date:**
Administrator's Name:	**Date:**
Office Staff's Name:	**Date:**
Cafeteria Staff's Name:	**Date:**
Bus Driver's Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**
Other Name:	**Date:**

OTHER COMMENTS:

_____

_____

_____

_____

_____

Nurse Signature: _____ Date: _____