Plan de acción/salud de emergencia para el asma del CMCSS
Año escolar 20 ___ - 20 ___

Nombre del estudiante: _____ Escuela: _____ Grado: _____ Maestro/a:_____

Aporte de padre/tutor

Desencadenantes del asma (encierre uno): Clima Actividad física Enfermedad Humo Polen Polvo Otro: _____

Alérgenos conocidos:_____

El estudiante ha tenido muchos ataques/exacerbaciones de asma graves: [ ] nunca [ ] semanalmente [ ] mensual

¿El estudiante toma medicación diaria para el asma?: [ ] Sí [ ] No Indique medicamentos: _____

*** Ubicación de la medicación de emergencia [ ] Clínica de enfermería [ ] Auto portar (ubicación ej. mochila): _____ [ ] Espaciador incluido**

HEA-F062 La autorización para medicamentos en la escuela debe completarse para **cada** medicamento.

School Nurse to complete below: ALWAYS REFER TO MEDICAL ORDERS

🙂 **GREEN ZONE** *Child is breathing good, no wheeze/cough, can work and play*	
Pretreatment: [ ] Not Required [ ] Administer medication *see attached authorization _____, Dose: _____ puffs (name of medication)	[ ] PRN: Prior to strenuous activity (recess/gym) [ ] Scheduled: Prior to strenuous activity (recess/gym)
😐 **YELLOW ZONE** *Child has some breathing problems, slow to speak, wheeze/cough, problems with work & play*	
Administer Quick-relief medication: [ ] Albuterol Dose: _____, may repeat after_____ # of puffs (minutes/hours) [ ] Other: _____ [ ] Nebulizer *see attached medication authorization	***Do this: *Call the school nurse*** *The student should feel better within 20 - 60 minutes of the quick relief medication. If they are getting worse, follow instructions in the RED ZONE.
🙁 **RED ZONE** *Child is breathing hard and fast, ribs pulling in, trouble talking*	
SYMPTOMS OF SEVERE ASTHMA ATTACK *Lips or fingertips turning blue, trouble talking or walking due to shortness of breath, cough constantly, decreased LOC, still in the red zone after 15 minutes, Call 911 and parent/guardian immediately	
Administer Quick-relief medication: [ ] Albuterol Dose: _____, may repeat after_____ # of puffs (minutes/hours) [ ] Other: _____ [ ] Nebulizer *see attached medication authorization	***Do this: *Call the school nurse***

Firma del padre/tutor: _____ Fecha: _____

School Nurse Signature:_____ Date:_____

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Año escolar 20 ___ - 20 ___

Nombre del estudiante: _____ Escuela: _____ Grado: _____ Maestro/a:_____

Firma del padre/tutor: _____ Fecha: _____

School Nurse Signature:_____ Date:_____