



EL ASMA

INFORMACIÓN ÚTIL, PLAN DE ACCIÓN Y FORMULARIOS ESCOLARES

ACP
ADVOCATE COMMUNITY PROVIDERS

EL ASMA



¿Qué es el asma?

El asma es una enfermedad de los pulmones que puede ser controlada, pero no curada. Algunos detonantes, como el humo de cigarrillo puede generar un ataque. Si convive con fumadores, asegúrese de que salgan a fumar fuera.

Cuando inhalamos para respirar, el aire fluye por nuestras vías respiratorias (tráquea), a través de tubos de aire (bronquios) y pequeñas vías respiratorias hacia los sacos de aire (alveolos) en los pulmones. El asma hace que las vías respiratorias en los pulmones se inflamen creando mucosidad, lo que hace que sea difícil respirar. Si no puede respirar bien, las actividades cotidianas, ejercicio e incluso caminar pueden ser muy difíciles. En circunstancias graves, si no recibe tratamiento rápidamente, el asma puede causar la muerte.

¿Qué puedo hacer para controlar mi asma?

- ✓ Con su médico, completen un Plan de Acción para el Asma (vea muestra incluida). Sígalo cada día. Lleve una copia adonde quiera que vaya. Tenga siempre una a mano en casa, en el trabajo, la escuela, etc.
- ✓ Para las escuelas, asegúrese de usar el formulario de Administración de Medicamento del Departamento de Salud (muestra en inglés incluida) que le dé su médico.
- ✓ Use medicamentos para controlar el asma, aun cuando se sienta bien.
- ✓ Siempre lleve consigo su medicina para el asma, en caso de ataque.
- ✓ Identifique y evite los detonadores que le provocan un ataque de asma.
- ✓ No fume ni esté cerca de personas cuando fuman.
- ✓ Vea a su médico si tiene gripe, infección de sinusitis u otra enfermedad que le provoque tos o afecte su respiración.
- ✓ Vacúnese contra el flu cada mes de octubre.
- ✓ Lávese las manos regularmente para evitar gérmenes.
- ✓ Hable con su médico acerca de una vacuna contra la neumonía (Pneumovax).

Para padres de niños en edad escolar

- Solicite una reunión con los maestros de su niño/a, la dirección y la enfermera de la escuela para que entiendan las necesidades de su hijo/a y estén preparados para responder a una emergencia.
- Asegúrese de que su hijo usa la medicina de control del asma incluso si se siente bien.
- Asegúrese de que su hijo lleva siempre consigo la medicina del asma, en caso de ataque.
- Asegúrese de que en la enfermería de la escuela de su hijo/a tienen la medicina que él/ella necesita en caso de un ataque de asma.
- Dígame a los maestros de su hijo/a, a la administración y a la enfermera cuando su hijo/a no se sienta bien.
- Asegúrese de que su hijo/a se siente cómodo al decirle al maestro cuándo no se siente bien.



Plan de Acción para el Asma

| | |
|-------------------------|---------------------|
| Nombre | Fecha de nacimiento |
| Dirección | # Récord médico |
| Médico Día # | Noche/Fin de semana |
| En caso de emergencia # | |
| Firma del Médico | |



Los colores de un semáforo le ayudarán a usar sus medicinas para el asma.

Verde representa la ¡Zona de Proceder! Use medicinas preventivas.

Amarillo representa la ¡Zona de Precaución! Añada medicinas para alivio rápido.

Rojo significa la ¡Zona de Peligro! Busque inmediatamente ayuda de un médico.

Su mejor marca de capacidad pulmonar

PROCEDER

Usted tiene todos estos:

- Respira bien
- No hay tos ni jadeo con silbido
- Duerme toda la noche
- Puede trabajar y jugar

Medida máxima de _____ a _____

PRECAUCIÓN

Usted tiene cualquiera de estos:

- Las primeras señales de un resfriado
- Se ha expuesto a algo que provoca el asma
- Tos
- Pecho apretado
- Silbido leve
- Tos por la noche

Medida máxima de _____ a _____

PELIGRO

Su asma empeora rápidamente:

- Las medicinas no ayudan
- Su respiración es fuerte y rápido
- La nariz se abre ampliamente
- Puede ver sus costillas
- No puede hablar bien

Lectura de capacidad pulmonar abajo _____

Use estas medicinas preventivas diariamente.

| MEDICINA | CUÁNTO | CUÁNTAS VECES/CUÁNDO |
|----------|--------|----------------------|
| | | |
| | | |
| | | |

Para el asma cuando practica ejercicio, tome:

| | | |
|--|--|--|
| | | |
|--|--|--|

Continúe con su medicina de zona verde, y AÑADA:

| MEDICINA | CUÁNTO | CUÁNTAS VECES/CUÁNDO |
|----------|--------|----------------------|
| | | |
| | | |
| | | |

LLAME A SU PROVEEDOR DE ATENCIÓN PRIMARIA.

Tome estas medicinas y llame a su médico inmediatamente.

| MEDICINA | CUÁNTO | CUÁNTAS VECES/CUÁNDO |
|----------|--------|----------------------|
| | | |
| | | |
| | | |

¡OBTENGA AYUDA DE UN MÉDICO AHORA MISMO! No tenga miedo de causar un alboroto. Su médico querrá verle inmediatamente. ¡Es importante! Si no se puede poner en contacto con su médico, vaya directamente a la sala de emergencia. **NO ESPERE.**

Haga una cita con su médico dentro de dos días a partir de una visita a la sala de emergencia o de una hospitalización.

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM—Office of School Health—School Year _____ - _____

| | | | |
|------------------------------------|--|--|--|
| Student Last Name | First Name | Middle Initial | Date of Birth ____/____/____ <small>M M D D Y Y Y Y</small> |
| | | | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Attach Student Photo To This Sheet | OSIS # _____ DOE District ____ Grade ____ | School Name, Number, Address, and Borough: | |

The Following Section Completed By Student's **HEALTH CARE PRACTITIONERS**

| | | |
|---|--|---|
| Diagnosis <input type="checkbox"/> Asthma | Control (see NAEPP Guidelines) <input type="checkbox"/> Well Controlled <input type="checkbox"/> Not Controlled <input type="checkbox"/> Unknown | Severity (see NAEPP Guidelines) <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent |
|---|--|---|

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

| | | | |
|---|----------------------------|----------------------------|--|
| History of near-death asthma requiring mechanical ventilation | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> U |
| History of life-threatening asthma (loss of consciousness or hypoxic seizure) | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> U |
| History of asthma-related PICU admissions (ever) | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> U |
| Received oral steroids within past 12 months | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> U _____ times last : ____/____/____ |
| History of asthma-related ER visits within past 12 months | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> U _____ times |
| History of asthma-related hospitalizations within past 12 months | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> U _____ times |
| History of food allergy or eczema, specify: _____ | <input type="checkbox"/> Y | <input type="checkbox"/> N | <input type="checkbox"/> U |

Quick Relief In-School Medication (Select ONE)

Albuterol MDI [Ventolin® MDI can be provided by school for shared usage (plus individual spacer)]:
[Parent must sign back]

MDI w/ spacer
 DPI

Other: Name: _____ Strength: _____
 Dose: _____ Route: _____ Time Interval: ____ hrs

In-School Instructions

Standard Order: Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat **ONCE**.

If in Respiratory Distress*: Call 911 and give 6 puffs/1AMP; may repeat q 20 minutes until EMS arrives.

Pre-exercise: 2 puffs/1 AMP 15-20 mins before exercise.

URI Symptoms or Recent Asthma Flare (within 5 days):
 2 puffs/1 AMP @ noon for 5 days.

Special Instructions:

Controller Medications for In-School Administration

(Recommended for Persistent Asthma, per NAEPP Guidelines)

Fluticasone MDI [Flovent® 110 mcg MDI can be provide by school for shared usage]: **[Parent must sign back]**

MDI w/ spacer
 DPI

Other: Name: _____ Strength: _____
 Dose: _____ Route: _____ Time Interval: ____ hrs

Standing Daily Dose:

____ puffs/1AMP ONCE a day at ____ AM or ____ PM
 Special Instructions:

Select the most appropriate option for this student:

- Nurse-Dependent Student: nurse must administer medication
 Supervised Student: student self-administers under adult supervision
 Independent Student: student is self-carry / self-administer (**Parent Initials Back)

Practitioner Initials

I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.

Home Medications (include over the counter)

Reliever _____
 Controller _____
 Other _____

| | | | | |
|---|---------------------------|--------------------------|---|---------------------|
| Health Care Practitioner (Please Print) | Last Name | First Name | Signature | Date ____/____/____ |
| Address | Tel. (____) _____ - _____ | Fax (____) _____ - _____ | NPI # _____ | |
| Email Address | NYS License # (Required) | | CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma. | |

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER—Office of School Health—School Year _____ – _____

The Following Section To Be Completed By Student's **Parent/Guardian**

I hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer medication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. **I understand that all provided medication must be supplied in its original and UNOPENED medication box.** I further understand that I must immediately advise the school nurse of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances. I understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner (whichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may include a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. I understand that 30 days before the above-mentioned MAF expiration date, an OSH health care practitioner may examine my child to evaluate his/her asthma symptoms and my child's response to the prescribed medication, and may issue a new MAF. If the OSH health care practitioner determines that no changes to the orders in the MAF are necessary, the OSH health care practitioner may issue a new MAF with the same orders to expire in one year unless my child's health care practitioner provides a new MAF. If an OSH health care practitioner determines based on an examination of my child and pertinent medical history that the orders in the MAF should be changed, the OSH health care practitioner may issue a new MAF with different orders. I, along with my child's health care practitioner of record, will be notified of the issuance of new MAF and of any change in the MAF orders. I further understand that I will have until 30 days before the expiration date of this MAF to submit a new MAF, or to object to this examination in writing, to the school nurse. If I do not submit a new MAF to the school nurse, or notify the school nurse in writing that I object to my child being examined by an OSH health care practitioner, by this deadline, my child may be examined and a new MAF may be issued. I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request/consent for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school. I understand that OSH and DOE and their employees and agents, may contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care practitioner and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial below for use of an epinephrine, asthma inhaler and other approved self-administered medications:**

Parent Initials

I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

Parent Initials

I consent to the school nurse storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

Parent Initials

I hereby certify that I have consulted with my child's health care practitioner and that I consent to the Office of School Health administering stock medication in the event that my child's asthma prescription medication is unavailable.

You must send your child's personal Metered Dose Inhaler (MDI) with your child on a school trip day so that he/she has it available. The stock medication is only for use while your child is in the school building.

**SIGN
HERE**

| | | | | |
|-------------------|-------|----|---------------------------|--------|
| Student Last Name | First | MI | Date of Birth ___/___/___ | School |
|-------------------|-------|----|---------------------------|--------|

Print Parent/Guardian's Name: _____ Parent/Guardian's Signature: _____

Date Signed ___/___/___ Parent/Guardian's Address: _____ Email: _____

Cell Phone (___) ___ - ___ - ___ Other Phone (___) ___ - ___ - ___ Email: _____

Alternate Emergency Contact Name: _____ Emergency Contact Phone: (___) ___ - ___ - ___

For OFFICE OF SCHOOL HEALTH (OSH) Only

Received By Name: _____ Date ___/___/___ Reviewed By Name: _____ Date ___/___/___

| | | |
|---|--|---|
| Self-Administers/Self-Carries: <input type="checkbox"/> Yes <input type="checkbox"/> No | Services Provided By: <input type="checkbox"/> Nurse <input type="checkbox"/> School-Based Health Center | OSH Public Health Advisor* <input type="checkbox"/> |
| Supervised Student* <input type="checkbox"/> Yes <input type="checkbox"/> No | | OSH Asthma Case Manager* <input type="checkbox"/> |

Signature and Title (RN OR MD/DO/NP): _____ IEP

Revisions per Office of School Health after consultation with prescribing practitioner: _____

*Respiratory Distress: includes breathlessness at rest, tachypnea, cyanosis, pallor, hunching forward, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, mouthing words, wheezing throughout expiration and inspiration or decreased or absent breath sounds, agitation, drowsiness, confusion or exceptionally quiet appearance.



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