

# Asthma Symptom Action Plan (ASAP)

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

**Asthma Severity:**  Intermittent  Mild Persistent  Moderate Persistent  Severe Persistent  
 Student has had many or severe asthma attacks in the past year (at increased risk)

**Asthma Triggers:**  Illness  Exercise  Dust  Pollen  Mold  Pets  Strong smells  Emotions  Cold air  Other: \_\_\_\_\_

**Daily controller medications given at home:**  YES  NO \_\_\_\_\_

**Exercise-induced symptoms:**  Pretreat with 2 puffs of Rescue Medication (see below) 15 minutes before exercise

1) Initial treatment of Asthma Symptoms\*: Prescription

**Rescue medication:**  Albuterol  Levalbuterol  Ipratropium bromide (Atrovent)  Other: \_\_\_\_\_

2 puffs inhaled every 4 hours with spacer (if available) as needed for COUGH, WHEEZE, SHORTNESS OF BREATH

## 2) Assess response to treatment in 10 minutes

Good Response	Poor Response				
No cough, wheeze, or difficulty breathing  	Still coughing, wheezing, or having difficulty breathing  				
<b>May continue rescue medication every 4 hours as needed</b>	<b>Give 4 puffs of rescue medication immediately</b> Contact school RN if not already present				
<ul style="list-style-type: none"> <li>Return to class</li> <li>Notify parent/guardian</li> </ul>	<b>3) REASSESS in 10 minutes</b>				
<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="color: red; font-weight: bold;">*Call 911 Immediately if student has these symptoms, then continue Plan</p> <ul style="list-style-type: none"> <li>Lips or fingernails are blue</li> <li>Trouble walking or talking due to shortness of breath</li> <li>Child's skin is sucked in around neck or ribs</li> </ul> </div>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center; color: green;">Good Response</th> <th style="text-align: center; color: red;">Poor Response</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;"> <ul style="list-style-type: none"> <li>Return to class</li> <li>Notify parent/guardian who should follow up in 1-3 days with health care provider</li> </ul> </td> <td style="vertical-align: top;"> <ul style="list-style-type: none"> <li>Contact parent/guardian who should pick up child and <b>take to health care provider today</b></li> <li>If severe distress and nonresponsive to treatments, or if parent/guardian unavailable, <b>call 911.</b></li> </ul> </td> </tr> </tbody> </table>	Good Response	Poor Response	<ul style="list-style-type: none"> <li>Return to class</li> <li>Notify parent/guardian who should follow up in 1-3 days with health care provider</li> </ul>	<ul style="list-style-type: none"> <li>Contact parent/guardian who should pick up child and <b>take to health care provider today</b></li> <li>If severe distress and nonresponsive to treatments, or if parent/guardian unavailable, <b>call 911.</b></li> </ul>
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**\*\* Please alert the asthma provider if the child consistently has asthma symptoms or needs albuterol (apart from pre-exercise) more than twice per week or has a severe attack at school.**

<input type="checkbox"/> YES <input type="checkbox"/> NO Parent and child feel that the child may carry and self-administer the inhaler	
<input type="checkbox"/> YES <input type="checkbox"/> NO Asthma provider agrees that the child may carry and self-administer the inhaler	
<input type="checkbox"/> YES <input type="checkbox"/> NO School nurse has assessed student's ability to responsibly administer and self-carry the inhaler	
MD/DO/NP/PA Printed Name and Contact Information:	MD/DO/NP/PA Signature:
Fax: _____ Phone: _____ Secure Email: _____	Date: _____
Parent/Guardian: I give written authorization for the medications listed in the Emergency Treatment Plan to be administered in school by the nurse or other trained school staff assigned by the site principal. I understand that designated school staff have my permission to communicate with the prescribing physician/health care provider on matters related to my child's asthma, this medication, and plan.	
Parent/guardian signature: _____	School Nurse Reviewed: _____
Date: _____	Date: _____

## **OPTIONAL LOG of rescue medication use**

**Not needed if medication dosing recorded elsewhere**

<b>Date/Time</b>	<b>Reason</b>	<b>Response</b>
	<input type="checkbox"/> pre-exercise <input type="checkbox"/> symptoms	<input type="checkbox"/> Good <input type="checkbox"/> Poor
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	<input type="checkbox"/> pre-exercise <input type="checkbox"/> symptoms	<input type="checkbox"/> Good <input type="checkbox"/> Poor
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