

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 	
May continue rescue medication every 4 hours as needed	Give 4 puffs of rescue medication immediately Contact school RN if not already present	
<ul style="list-style-type: none"> • Return to class • Notify parent/guardian 	3) REASSESS in 10 minutes	
<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="color: red; font-weight: bold; margin: 0;">*Call 911 Immediately if student has these symptoms, then continue Plan</p> <ul style="list-style-type: none"> • Lips or fingernails are blue • Trouble walking or talking due to shortness of breath • Child's skin is sucked in around neck or ribs </div>	Good Response	Poor Response
	<ul style="list-style-type: none"> • Return to class • Notify parent/guardian who should follow up in 1-3 days with health care provider 	<ul style="list-style-type: none"> • Contact parent/guardian who should pick up child and take to health care provider today • If severe distress and nonresponsive to treatments, or if parent/guardian unavailable, call 911.

**** 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.**

YES NO Parent and child feel that the child may carry and self-administer the inhaler

YES NO Asthma provider agrees that the child may carry and self-administer the inhaler

YES 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: _____

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 	
May continue rescue medication every 4 hours as needed	Give 4 puffs of rescue medication immediately Contact school RN if not already present	
<ul style="list-style-type: none"> Return to class Notify parent/guardian 	3) REASSESS in 10 minutes	
<div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;"> <p style="color: red; font-weight: bold; margin: 0;">*Call 911 Immediately if student has these symptoms, then continue Plan</p> <ul style="list-style-type: none"> Lips or fingernails are blue Trouble walking or talking due to shortness of breath Child's skin is sucked in around neck or ribs </div>	<p style="color: green; font-weight: bold; margin: 0;">Good Response</p> <ul style="list-style-type: none"> Return to class Notify parent/guardian who should follow up in 1-3 days with health care provider 	<p style="color: red; font-weight: bold; margin: 0;">Poor Response</p> <ul style="list-style-type: none"> Contact parent/guardian who should pick up child and take to health care provider today If severe distress and nonresponsive to treatments, or if parent/guardian unavailable, call 911.

**** 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.**

YES NO Parent and child feel that the child may carry and self-administer the inhaler

YES NO Asthma provider agrees that the child may carry and self-administer the inhaler

YES 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: _____