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
• Return to class • Notify parent/guardian	**3) REASSESS in 10 minutes**

*Call 911 Immediately if student has these symptoms, then continue Plan	Good Response	Poor Response
• Lips or fingernails are blue • Trouble walking or talking due to shortness of breath • Child's skin is sucked in around neck or ribs	• Return to class • Notify parent/guardian who should follow up in 1-3 days with health care provider	• Contact parent/guardian who sho pick up child and **take to health care provider today** • If severe distress and nonrespons to treatments, or if parent/guardiar unavailable, **call 911.**

**** Please alert the asthma provider if the child consistently has asthma symptoms or needs albute (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 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: