**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**

|  |  |
| --- | --- |
| **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**
 | 1. **REASSESS in 10 minutes**
 |
|  | **Good Response** | **Poor Response** |
| **\*Call 911 Immediately if student has these symptoms, then continue Plan** |  | ● Return to class● Notify parent/guardian who should **follow up in 1-3 days with health care provider** | ● 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.** |
| * Lips or fingernails are blue
* Trouble walking or talking due to shortness of breath
* Child’s skin is sucked in around neck or ribs
 |

1. **Assess response to treatment in 10 minutes**

**\*\* 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:Fax: Phone: Secure Email: | MD/DO/NP/PA Signature: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:Date: | School Nurse Reviewed:Date: |

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

**Not needed if medication dosing recorded elsewhere**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date/Time** | **Reason** | **Response** |  | **Date/Time** | **Reason** | **Response** |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |
|  | □ pre-exercise□ symptoms | □ Good□ Poor |  |  | □ pre-exercise□ symptoms | □ Good□ Poor |

**\*\* 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.**