LA MESA-SPRING VALLEY SCHOOLS

Asthma Symptom Action Plan (ASAP)

Student Name:	**Birthdate:**
Asthma Severity: □ Intermittent □ Mild Persistent □Moderate Persistent □Severe Persistent □ Student has had many or severe asthma attacks/exacerbations 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**

Good Response	**Poor Response**
● 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.**

*Call 911 Immediately if student has these symptoms, then continue Plan
• → Lips or fingernails are blue
• → Trouble walking or talking due to shortness of breath
• → Child's skin is sucked in around neck or ribs

□ **YES** □ **NO Parent and child feel that the child may carry and self-administer their 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 Asthma Symptom Action 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:

**** Please alert the asthma provider if the child consistently has asthma symptoms or needs rescue medication (apart from pre-exercise) more than twice per week or has a severe attack at school.**