Asthma Action Plan (AAP)

Individualized Healthcare Plan (IHP)/Emergency Action Plan (EAP)/Medication Authorization & Self-Administration Form

in accordance with UCA 26-41-104

Utah Department of Health/Utah State Board of Education

School Year:	Picture

STUDENT INFORMATION

Student:	DOB:	Grade:	School:
Parent:	Phone:		Email:
Physician:	Phone:		Fax or email:
School Nurse:	School Phone:		Fax or email:

Severity Classification

☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Triggers

☐ Illness ☐ Exercise ☐ Animals ☐ Smoke ☐ Dust ☐ Food ☐ Weather ☐ Air Quality ☐ Pollen ☐ Other (specify):

Air Quality

Student should stay indoors when Air Quality Index is:

☐ Moderate	☐ Unhealthy for sensitive groups	☐ Unhealthy	☐ Other:

Exercise

Take quick-relief medication (see medication order in Yellow section below):

☐ Before exercise/exposure to a trigger

☐ Other (specify):

Green: Doing Great!

Student has ALL of these:

- Breathing is easy
- No cough or wheeze
- Able to work and play normally

Action

Controller Medication (taken at home)	How Much?	How Often?

Yellow: Mild to Moderate Distress

Student has ANY of these:

- Coughing or wheezing
- Tight chest
- Shortness of breath
- Waking up at night

Action

Quick-Relief Medication	How Much?	How Often?

Administer Via	
☐ Inhaler ☐ Nebulizer ☐ Inhaler with spacer	☐ Student is independent ☐ Student needs assistance ☐ Student needs supervision

1. Restrict physical activity and allow to rest upright.
2. Do not leave student unattended. Observe continuously for 15 minutes.
3. Notify parent/guardian.
4. If improved (breathing smooth and easy, no coughing or wheezing) may return to class.
5. **If no improvement call EMS and move to Red section below.**

Red: Severe Respiratory Distress

Student has ANY of these:

- Trouble eating, walking or talking
- Breathing hard and fast
- Medicine isn't helping
- Rib or neck muscles show when breathing in
- Color changes in lips, nail beds, skin

Action

Call EMS!

1. Repeat ____ puffs of Quick-Relief Medication (each 15-30 seconds apart) every ____ minutes until medical help arrives.
2. Encourage slow breaths and allow individual to rest.
3. Update parent/guardian.
4. Do not leave student unattended. Observe continuously until EMS arrives

☐ Additional Orders (specify):

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Student Name:	**DOB:**	**School Year:**

PRESCRIBER TO COMPLETE

The above named student is under my care. The above reflects my plan of care for the above named student.
☐ **It is** medically appropriate for the student to carry and self-administer asthma medication, when able and appropriate, and be in possession of asthma medication and supplies at all times.
☐ **It is not** medically appropriate for the student to carry and self-administer this asthma medication. Please have the appropriate/designated school personnel maintain this student's medication for use if having symptoms at school.

Prescriber Name:	Phone:
Prescriber Signature:	Date:

PARENT TO COMPLETE

Parental Responsibilities:
• The parent or guardian is to furnish the asthma medication and bring to the school in the current original pharmacy container and pharmacy label with the child's name, medication name, administration time, medication dosage, and healthcare provider's name.
• The parent or guardian, or other designated adult will deliver to the school and replace the asthma medication when empty.
• If a student has a change in their prescription, the parent or guardian is responsible for providing the newly prescribed information and dose information as described above to the school. The parent or guardian will complete an updated Asthma Action Plan before designated staff can administer the updated asthma medication prescription.

Parent/Guardian Authorization
☐ **I authorize** my child to carry and self-administer the prescribed medication described above. My student is responsible for, and capable of, possessing or possessing and self-administering an asthma inhaler per UCA 53G-9-503. My child and I understand there are serious consequences for sharing any medication with others.
☐ **I do not authorize** my child to carry and self-administer this medication. Please have the appropriate/designated school personnel maintain my child's medication for use in an emergency.
☐ **I authorize** the appropriate/designated school personnel maintain my child's medication for use in emergency.

Parent Signature:	Date:

As parent/guardian of the above named student, I give my permission to the school nurse and other designated staff to administer medication and follow protocol as identified in the asthma action plan. I agree to release, indemnify, and hold harmless the above from lawsuits, claim expense, demand or action, etc., against them for helping this student with asthma treatment, provided the personnel are following prescriber instruction as written in the asthma action plan above. Parent/Guardians and students are responsible for maintaining necessary supplies, medication and equipment. I give permission for communication between the prescribing health care provider, the school nurse, the school medical advisor and school-based clinic providers necessary for asthma management and administration of medication. I understand that the information contained in this plan will be shared with school staff on a need-to-know basis and that it is the responsibility of the parent/guardian to notify school staff whenever there is any change in the student's health status or care.

Parent Name:	Signature:	Date:
Emergency Contact Name:	Relationship:	Phone:

SCHOOL NURSE (or principal designee if no school nurse)

☐ Signed by prescriber and parent	☐ Medication is appropriately labeled	☐ Medication log generated

Medication is kept: ☐Student Carries ☐Backpack ☐Classroom ☐ Health Office ☐ Front Office ☐ Other (specify):

Asthma Action Plan distributed to 'need to know' staff: ☐ Teacher(s) ☐ PE teacher(s) ☐ Transportation ☐ Front Office/Admin ☐Other (specify):

School Nurse Signature:	Date: