Asthma action plan (AAP) Simplified individualized healthcare plan/emergency action plan Medication authorization and self-administration form in accordance with UCA 26B-4-408 Utah Department of Health and Human Services/Utah State Board of Education	School year:	Picture

Student information			
Student:	Date of birth:	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:				**Exercise** Take quick-relief medication (see medication order in yellow section below): Before exercise/exposure to a trigger Other (specify):
O Moderate	O Unhealthy for sensitive groups	O Unhealthy	O Other:	

Green: doing great!	Action		
Student has **all** of these: - Breathing is easy - No cough or wheeze - Able to work and play normally	Controller medication (taken at home)	How much?	How often?

Yellow: mild to moderate distress	Action		
Student has **any** of these: - Coughing or wheezing - Tight chest - Shortness of breath - Waking up at night	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 the student to rest upright. 2. Do not leave student unattended. Observe continuously for 15 minutes. 3. Notify the parent or guardian of the distress. 4. If improved (breathing smooth and easy, no coughing or wheezing), the student may return to class. **5. If no improvement, call 911 and move to Red section below.**		

Red: Severe respiratory distress	Action
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	***Call 911!*** 1. Repeat ____ puffs of quick-relief medication (each 15-30 seconds apart) every ____ minutes until medical help arrives. 2. Encourage slow breaths and allow the student to rest. 3. Update the parent or guardian on the student's status. 4. Do not leave the student unattended. Observe continuously until EMS arrives. Additional orders (specify):

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Asthma action plan (AAP)

Student name:	Date of birth:	School year:

Prescriber completes this section

The above-named student is under my care. **The above reflects my plan of care for this 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. The appropriate/designated school personnel should keep this student's medication for use if having symptoms at school.

Prescriber name:	Phone:
Prescriber signature:	Date:

Parent or legal guardian completes this section

Parents are responsible to:

• Bring the student's asthma medication to the school. The medication must be in the original pharmacy container with a pharmacy label that has the child's name, medication name, administration time, medication dosage, and healthcare provider's name.

• Replace the asthma medication when empty.

• Provide any new prescribing or dose information to the school if there is a change in the student's prescription.

• Complete an updated Asthma Action Plan before designated staff can administer the updated 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 26B-4-408. 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. The appropriate/designated school personnel should keep my child's medication for use in an emergency.

☐ **I authorize** the appropriate/designated school personnel to keep my child's medication for use in emergency.

Parent signature:	Date:

As the parent or legal 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. I am responsible for maintaining necessary supplies, medication, and equipment. I give permission for communication between the prescribing health care provider, school nurse, 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 my responsibility to notify school staff whenever there is any change in the student's health status or care.

Parent name:	Signature:	Date:
Other emergency contact name:	Relationship to student:	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 staff ☐ Front office/admin staff ☐ Other (specify):

School nurse signature:	Date: