CHULA VISTA ELEMENTARY SCHOOL DISTRICT

Asthma Action Plan

Attach child's photo

Name:	**DOB:**	**Date of Plan:**
School:	**Grade/Room:**	
Anaphylaxis: ☐ Yes ☐ No	**Allergies:**	

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ **Student has had many or severe asthma attacks in the past year**

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 Rescue Medication (see below) 15 minutes before exercise

1) Initial treatment of Asthma Symptoms

Rescue medication protocol: ☐ Albuterol ☐ Levalbuterol ☐ Ipratropium bromide (Atrovent)
☐ Other: _____

☐ **Two** ☐ **Four puffs every ____ hours as needed for Cough, Wheezing, Shortness of Breath**

2) Assess response to initial treatment in 10 minutes

Poor Response	**Good Response**
Still coughing, wheezing, or having difficulty breathing	No cough, wheeze, or difficulty breathing
Give ☐ Two ☐ Four puffs of rescue medication <u>again</u> and contact school RN if not already present	• Return to class • Notify parent/guardian ☐ Yes ☐ No

3) Reassess response to <u>second</u> treatment in 10 minutes

Poor Response
• Contact parent/guardian to pick up child and **take to health care provider today** • If severe distress and nonresponsive to treatments, or if parent/guardian unavailable, **call 911.**

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 License and Contact Information: Printed Name: Lic. #	Signature:
Phone: Fax:	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 Contact Information: Printed Name:	Signature:
Phone:	Date: