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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Asthma action plan (AAP)<br>Emergency action plan<br>Medication authorization and self-administration form<br>in accordance with UCA 26B-4-408<br>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:                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                            |            |
| <b>Severity classification</b> <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild persistent <input type="checkbox"/> Moderate persistent <input type="checkbox"/> Severe persistent<br><b>Triggers</b><br><input type="checkbox"/> Illness <input type="checkbox"/> Exercise <input type="checkbox"/> Animals <input type="checkbox"/> Smoke <input type="checkbox"/> Dust <input type="checkbox"/> Food <input type="checkbox"/> Weather <input type="checkbox"/> Air quality <input type="checkbox"/> Pollen<br><input type="checkbox"/> Other (specify): |                |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                            |            |
| <b>Air quality</b><br>Student should stay indoors when air quality index is:<br><div> <input type="radio"/> Moderate           <input type="radio"/> Unhealthy for sensitive groups           <input type="radio"/> Unhealthy           <input type="radio"/> Other:         </div>                                                                                                                                                                                                                                                                                           |                | <b>Exercise</b><br>Take quick-relief medication (see medication order in yellow section below):<br>Before exercise/exposure to a trigger<br>Other (specify):                                                                                                                                                                                                                            |                                                                                                                                                            |            |
| Green: doing great!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | Action                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                            |            |
| Student has <b>all</b> of these:<br>- Breathing is easy<br>- No cough or wheeze<br>- Able to work and play normally                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                | Controller medication (taken at home)                                                                                                                                                                                                                                                                                                                                                   | How much?                                                                                                                                                  | How often? |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                            |            |
| Yellow: mild to moderate distress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                | Action                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                            |            |
| Student has <b>any</b> of these:<br>- Coughing or wheezing<br>- Tight chest<br>- Shortness of breath<br>- Waking up at night                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                | Quick-relief medication                                                                                                                                                                                                                                                                                                                                                                 | How much?                                                                                                                                                  | How often? |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                            |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | Administer via                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Student is independent<br><input type="checkbox"/> Student needs assistance<br><input type="checkbox"/> Student needs supervision |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | <input type="checkbox"/> Inhaler <input type="checkbox"/> Nebulizer<br><input type="checkbox"/> Inhaler with spacer                                                                                                                                                                                                                                                                     |                                                                                                                                                            |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                | 1. Restrict physical activity and allow the student to rest upright.<br>2. Do not leave student unattended. Observe continuously for 15 minutes.<br>3. Notify the parent or guardian of the distress.<br>4. If improved (breathing smooth and easy, no coughing or wheezing), the student may return to class.<br>5. <b>If no improvement, call 911 and move to Red section below.</b>  |                                                                                                                                                            |            |
| Red: Severe respiratory distress                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                | Action                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                            |            |
| Student has <b>any</b> of these:<br>- Trouble eating, walking, or talking<br>- Breathing hard and fast<br>- Medicine isn't helping<br>- Rib or neck muscles show when breathing in<br>- Color changes in lips, nail beds, skin                                                                                                                                                                                                                                                                                                                                                |                | <b>Call 911!</b><br>1. Repeat ___ puffs of quick-relief medication (each 15-30 seconds apart) every ___ minutes until medical help arrives.<br>2. Encourage slow breaths and allow the student to rest.<br>3. Update the parent or guardian on the student's status.<br>4. Do not leave the student unattended. Observe continuously until EMS arrives.<br>Additional orders (specify): |                                                                                                                                                            |            |
| Continued on next page                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                |                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                            |            |

## Asthma action plan (AAP)

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------|
| Student name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Date of birth:                                               | School year:                                      |
| Prescriber completes this section                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                              |                                                   |
| <p>The above-named student is under my care. <b>The above reflects my plan of care for this student.</b></p> <p><input type="checkbox"/> <b>It is</b> 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.</p> <p><input type="checkbox"/> <b>It is not</b> 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.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                              |                                                   |
| Prescriber name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Phone:                                                       |                                                   |
| Prescriber signature:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Date:                                                        |                                                   |
| Parent or legal guardian completes this section                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                              |                                                   |
| <p><b>Parents are responsible to:</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>Replace the asthma medication when empty.</li> <li>Provide any new prescribing or dose information to the school if there is a change in the student's prescription.</li> <li>Complete an updated Asthma Action Plan before designated staff can administer the updated prescription.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                              |                                                   |
| <p><b>Parent/guardian authorization</b></p> <p><input type="checkbox"/> I <b>authorize</b> 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.</p> <p><input type="checkbox"/> I <b>do not authorize</b> 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.</p> <p><input type="checkbox"/> I <b>authorize</b> the appropriate/designated school personnel to keep my child's medication for use in emergency.</p>                                                                                                                                                                                                                                                                               |                                                              |                                                   |
| Parent signature:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                              | Date:                                             |
| <p>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.</p> |                                                              |                                                   |
| Parent name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Signature:                                                   | Date:                                             |
| Other emergency contact name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Relationship to student:                                     | Phone:                                            |
| School nurse (or principal designee if no school nurse)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                              |                                                   |
| <input type="checkbox"/> Signed by prescriber and parent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Medication is appropriately labeled | <input type="checkbox"/> Medication log generated |
| Medication is kept: <input type="checkbox"/> Student carries <input type="checkbox"/> Backpack <input type="checkbox"/> Classroom <input type="checkbox"/> Health office <input type="checkbox"/> Front office <input type="checkbox"/> Other (specify):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                              |                                                   |
| Asthma action plan distributed to "need to know" staff: <input type="checkbox"/> Teacher(s) <input type="checkbox"/> PE teacher(s)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                              |                                                   |
| <input type="checkbox"/> Transportation staff <input type="checkbox"/> Front office/admin staff <input type="checkbox"/> Other (specify):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                              |                                                   |
| School nurse signature:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                              | Date:                                             |