Student Asthma/Allergy Action Plan

(This Page To Be Completed By Health Care Provider)

Student Name: _____ **Date Of Birth:** ____/____/____ (MONTH) (DAY) (YEAR)

☐ **Exercise Pre-Treatment:** Administer inhaler (**2 inhalations**) 15-30 minutes prior to exercise. (e.g., PE, recess, etc).

☐ Albuterol HFA inhaler (Proventil, Ventolin, ProAir)
☐ Albuterol DPI (ProAir RespiClick)
☐ Levalbuterol (Xopenex HFA)
☐ Use inhaler with valved holding chamber
☐ Other: _____

Asthma Treatment

Give **quick relief medication** when student has asthma symptoms, such as coughing, wheezing or tight chest.

☐ Albuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
☐ Albuterol DPI (ProAir RespiClick) 2 inhalations
☐ Levalbuterol (Xopenex HFA) 2 inhalations
☐ Use inhaler with valved holding chamber
☐ Albuterol inhaled **by nebulizer** (Proventil, Ventolin, AccuNeb)
☐ .63 mg/3 mL ☐ 1.25 mg/3 mL ☐ 2.5 mg/3 ml
☐ Levalbuterol inhaled **by nebulizer** (Xopenex)
☐ 0.31 mg/3 mL ☐ 0.63 mg/3 mL ☐ 1.25 mg/3 mL
☐ May carry & self-administer inhaler (MDI)
☐ Other: _____

Closely Watch the Student after Giving Quick Relief Medication

If, after 10 minutes:

- Symptoms are better, student may return to classroom **after** notifying parent/guardian
- Symptoms are not better, give the treatment again and notify parent/guardian right away
- If student continues to get worse, CALL 911 and use the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol

Anaphylaxis Treatment

Give **epinephrine** when student has allergy symptoms, such as hives, hard to breathe (chest or neck "sucking in"), lips or fingernails turning blue, or trouble talking (shortness of breath).

☐ EpiPen® 0.3 mg ☐ EpiPen® Jr 0.15 mg
☐ AUVI-Q® 0.3 mg ☐ AUVI-Q® Jr. 0.15 mg
☐ Other: _____
☐ May carry & self-administer epi auto-injector
☐ **Use epinephrine auto-injector immediately upon exposure to known allergen**
☐ **If symptoms do not improve or they return, epinephrine can be repeated after 5 minutes or more**

Lay person flat on back and raise legs. If vomiting or difficulty breathing, let them lie on their side.

CALL 911 After Giving Epinephrine & Closely Watch the Student

- Notify parent/guardian immediately
- **Even if student gets better, the student should be watched for more signs/ symptoms of anaphylaxis in an emergency facility**
- If student does not get better or continues to get worse, use the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol

☐ This Student has the ability to self-manage Student's Health Condition and I authorize Student to self-manage in accordance with this Plan. If medications are self-administered, the school staff **must** be notified immediately.

Additional information: *(i.e. asthma triggers, allergens)* _____

Health Care Provider name: *(please print)* _____ **Phone:** _____

Health Care Provider signature: _____ **Date:** _____

Parent signature: _____ **Date:** _____

Reviewed by school nurse/nurse designee: _____ **Date:** _____

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Parent/Guardian)

Student Name: _____ **Age:** _____ **Grade:** _____

School: _____ **Homeroom Teacher:** _____

Parent/Guardian: _____ **Phone(** **)** _____ **(** **)** _____

Parent//Guardian: _____ **Phone(** **)** _____ **(** **)** _____

Emergency Contact: _____ **Phone(** **)** _____ **(** **)** _____

Known Asthma Triggers: Please check the boxes to identify what can cause an asthma episode for your student.

- ☐ Exercise
- ☐ Respiratory/viral infections
- ☐ Odors/fumes/smoke
- ☐ Mold/mildew
- ☐ Pollens
- ☐ Animals/dander
- ☐ Dust/dust mites
- ☐ Grasses/trees
- ☐ Temperature/weather—humidity, cold air, etc.
- ☐ Pesticides
- ☐ Food—please list below
- ☐ Other—please list: _____

Known Allergy/Intolerance: Please check those which apply and describe what happens when your child eats or comes into contact with the allergen.

Peanuts	☐	_____
Tree Nuts	☐	_____
Fish/shellfish	☐	_____
Eggs	☐	_____
Soy	☐	_____
Wheat	☐	_____
Milk	☐	_____
Medication	☐	_____
Latex	☐	_____
Insect stings	☐	_____
Other	☐	_____

Notice: If your child has been prescribed epinephrine (such as an EpiPen®) for an allergy, you must provide epinephrine at school. If your student needs a special diet to limit or avoid foods, your doctor will need to complete the form *"Medical Statement Form to Request Special Meals and/or Accommodations"* which can be found on the website—*www.airenebraska.org*

Medicines: Please list medicines used at home and/or to be given at school.

Medicine Name	Amount/Dose	When does it need to be given

I understand that all medicines to be given at school must be provided by the parent/guardian.

Parent signature: _____ **Date:** _____

Reviewed by school nurse/nurse designee: _____ **Date:** _____

Version: 06/17

Nebraska Department of Health and Human Services

Self-management Of Asthma and Severe Allergy (Anaphylaxis) at School Consent/release form

Parental consent/release in writing is required annually and must be accompanied by:

- **Signed physician authorization for self-management of asthma/anaphylaxis at school.**
- **Current written medical management plan. The school can provide a form for your use.**
- **We strongly recommend you allow us to keep an extra supply of your child's medications at school.**

PARENT/GUARDIAN: By signing below, you acknowledge the following:

1. You are requesting that your student be allowed to self-manage his or her asthma or allergy condition at school.
2. You have confidence that your student has the knowledge and skills need to self-manage his or her asthma or allergy condition at school.
3. You understand that you are not required to make this request on behalf of your child. Your child may utilize the health office for asthma and allergy cares. Your child may request assistance from qualified school health personnel at any time during the school day.
4. If your student injures school personnel or another student as a result of misuse of asthma or allergy supplies, you shall be responsible for any and all cost associated with such injury.
5. The school and its employees are not liable for any injury or death arising from a student's self-management of his or her asthma or allergy condition.
6. You will indemnify and hold harmless the school and its employees and agents against any claim arising from a student's self-management of his or her asthma or allergy.

Parent/Guardian Printed Name _____ Student Printed Name _____

Parent/Guardian Signature _____ Date _____

THIS PORTION RECOMMENDED, NOT REQUIRED

STUDENT: By signing below, you agree that you understand:

1. You must not share, or allow another student to handle, your medications or supplies.
2. You will notify the school nurse or other designated adult when you have used your medication.
3. If you don't feel better after using your medication, you will seek help from school personnel.

Student Signature _____ Date _____

Student Printed Name _____

Reference: Neb. Rev. Stat. 79-224 (2006).