Student Asthma/Allergy Action Plan

(This Page To Be Completed By Health Care Provider)

Student Name: ______________________ **Weight:** ________ **Date Of Birth:** ____/____/____ (MONTH) (DAY) (YEAR)

☐ **Exercise Pre-Treatment:** Administer inhaler **(2 inhalations)** 15-30 minutes prior to exercise. ☐ PE ☐ Recess

☐ Albuterol /Levalbuterol HFA inhaler (Proventil, Ventolin, ProAir. Xopenex) ☐ Use inhaler with valved holding chamber

☐ Albuterol DPI (ProAir RespiClick) ☐ May carry & self-administer quick relief medication

Asthma Treatment

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

☐ Albuterol /Levalbuterol HFA - 2-4 inhalations (Proventil, Ventolin, ProAir, Xopenex)

☐ Use inhaler with valved holding chamber

☐ Albuterol DPI (ProAir RespiClick) - 2 inhalations

☐ 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 quick relief medication

If symptoms do not improve, quick relief medication can be repeated after 10 minutes

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

If student continues to get worse, CALL 911 & 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, with difficulty breathing (chest or neck "sucking in"), lips or fingernails turning blue, or trouble talking (shortness of breath) or vomiting or collapse.

☐ EpiPen® 0.3 mg ☐ EpiPen® Jr 0.15 mg

☐ AUVI-Q® 0.3 mg ☐ AUVI-Q® Jr. 0.15 mg

☐ AUVI-q® 0.1 mg

☐ Other: ______________________

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

☐ **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**

☐ May carry & self-administer epi auto-injector

***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 toget 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:** __________

 Version: 06/18

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:** ______________

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).

This Action Plan is for students in school K-12 in Nebraska. Your patient will need a separate action plan for a home, work or a childcare setting.

The Student Asthma/Allergy Action Plan has some important updates:

⇒ There have been some updates to the language in the interest of health literacy as our understanding and knowledge continues to grow.

⇒ Medications have been updated to reflect what is currently on the market.

⇒ There is a **new** check box and line for health care providers to check which instructs administration of epinephrine immediately upon ingestion of a known allergen.

⇒ The check box stating that you have reviewed the use of medications in order for a student to self-manage at school MUST NOW BE CHECKED.

The Student Asthma/Allergy Action Plan has two pages:

- Page 1 is for the physician to complete and sign.
  Health Care Providers—please give your patients **BOTH pages!**
- Page 2 is for the parent/caregiver to complete and sign.
- **This action plan is only valid for students in K-12 grades.** If they are younger or older, please use a different action plan.

EMPHASIZE THE FOLLOWING TO YOUR FAMILIES AND PATIENTS!

In order for the school to have all the information needed, **BOTH** *pages should be completed and presented to the school,* **ALONG** *with the prescribed medications.*