Student Asthma/Allergy Action Plan

(This Page To Be Completed By Physician)

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)
❑ Levalbuterol (Xopenex HFA)
❑ Pirbuterol inhaler (Maxair)
❑ Use inhaler with spacer/valved holding chamber
❑ May carry & self-administer inhaler (MDI)
❑ Other: _____

Asthma Treatment

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

❑ Albuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
❑ Levalbuterol (Xopenex HFA) 2 inhalations
❑ Pirbuterol (Maxair) 2 inhalations
❑ Use inhaler with spacer/valved holding chamber
❑ May carry & self-administer inhaler (MDI)
❑ 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
❑ Other: _____

Closely Observe the Student after Giving Quick Relief Medication

If, after 10 minutes:

- Symptoms are improved, student may return to classroom after notifying parent/guardian
- No improvement in symptoms, repeat the treatment and notify parent/guardian immediately
- ***If student continues to worsen, CALL 911 and initiate the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol***

Anaphylaxis Treatment

Give **epinephrine** when student experiences allergy symptoms, such as hives, difficulty breathing (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™ 0.15 mg

❑ Other: _____

❑ May carry & self-administer epinephrine

***CALL 911* After Giving Epinephrine & Closely Observe the Student**

- Notify parent/guardian immediately
- ***Even* if student improves, the student should be observed for recurrent symptoms of anaphylaxis in an emergency medical facility**
- ***If student does not improve or continues to worsen, initiate the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol***

☒ This student has a medical history of asthma and/or anaphylaxis and I have reviewed the use of the above-listed medication(s). If medications are self-administered, the school staff **must** be notified.

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

_____

Physician name: *(please print)* _____ **Phone:** _____

Physician signature: _____ **Date:** _____

Parent signature: _____ **Date:** _____

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

Version: 02/13

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Parent/Guardian)

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

School: _____ **Homeroom Teacher:** _____

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

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

Alternate Emergency Contact: _____ **Phone(H)** _____ **(W)** _____

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 (e.g. EpiPen) for an allergy, it is also necessary to provide epinephrine at school. If your student requires a special diet to limit or eliminate foods, the school may ask your physician to complete the form *"Medical Statement for Students Requiring Special Meals"*.

Daily Medications: Please list daily medications used at home and/or to be administered at school.

Medication Name	Amount/Dose	When administered

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

Parent signature: _____ **Date:** _____

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

Version: 02/13