

# 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: \_\_\_\_\_

# 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.

- |                                                                       |                                                       |                                                 |                                        |
|-----------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------|----------------------------------------|
| <input type="checkbox"/> Exercise                                     | <input type="checkbox"/> Respiratory/viral infections | <input type="checkbox"/> Odors/fumes/smoke      | <input type="checkbox"/> Mold/mildew   |
| <input type="checkbox"/> Pollens                                      | <input type="checkbox"/> Animals/dander               | <input type="checkbox"/> Dust/dust mites        | <input type="checkbox"/> Grasses/trees |
| <input type="checkbox"/> Temperature/weather—humidity, cold air, etc. | <input type="checkbox"/> Pesticides                   | <input type="checkbox"/> Food—please list below |                                        |
| <input type="checkbox"/> 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        | <input type="checkbox"/> | _____ |
| Tree Nuts      | <input type="checkbox"/> | _____ |
| Fish/shellfish | <input type="checkbox"/> | _____ |
| Eggs           | <input type="checkbox"/> | _____ |
| Soy            | <input type="checkbox"/> | _____ |
| Wheat          | <input type="checkbox"/> | _____ |
| Milk           | <input type="checkbox"/> | _____ |
| Medication     | <input type="checkbox"/> | _____ |
| Latex          | <input type="checkbox"/> | _____ |
| Insect stings  | <input type="checkbox"/> | _____ |
| Other          | <input type="checkbox"/> | _____ |

**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: \_\_\_\_\_