

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).

- | | |
|--|---|
| <input type="checkbox"/> Albuterol HFA inhaler (Proventil, Ventolin, ProAir) | <input type="checkbox"/> Use inhaler with spacer/valved holding chamber |
| <input type="checkbox"/> Levalbuterol (Xopenex HFA) | <input type="checkbox"/> May carry & self-administer inhaler (MDI) |
| <input type="checkbox"/> Pirbuterol inhaler (Maxair) | <input type="checkbox"/> 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: _____