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).

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:** _____

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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:** _____

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