

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Health Care Provider)

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 valved holding chamber |
| <input type="checkbox"/> Albuterol DPI (ProAir RespiClick) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Levalbuterol (Xopenex HFA) | |

Asthma Treatment

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

- Albuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
- Albuterol DPI (ProAir RespiClick) 2 inhalations
- Levalbuterol (Xopenex HFA) 2 inhalations
- Use inhaler with valved holding chamber
- 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 inhaler (MDI)
- Other: _____

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
- Symptoms are not better, give the treatment again and notify parent/guardian right away
- **If student continues to get worse, CALL 911 and 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, hard to breathe (chest or neck "sucking in"), lips or fingernails turning blue, or trouble talking (shortness of breath).

- | | |
|---|--|
| <input type="checkbox"/> EpiPen® 0.3 mg | <input type="checkbox"/> EpiPen® Jr 0.15 mg |
| <input type="checkbox"/> AUVI-Q® 0.3 mg | <input type="checkbox"/> AUVI-Q® Jr. 0.15 mg |
| <input type="checkbox"/> Other: _____ | |
- May carry & self-administer epi auto-injector
 - 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**

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

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 to get 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: _____

BOTH PAGES MUST BE COMPLETED AND SUBMITTED TO THE SCHOOL OFFICE

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.

<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 (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: _____