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.

- ❑ 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 (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*

Daily Medicines: Please list daily medicines used at home and/or to be given at school.

Medicine Name	Amount/Dose	When does it need to 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:** _____

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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).

❑ Albuterol HFA inhaler (Proventil, Ventolin, ProAir)
❑ Levalbuterol (Xopenex HFA)
❑ Pirbuterol inhaler (Maxair)
❑ Use inhaler with valved holding chamber
❑ Other: _____

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
❑ Levalbuterol (Xopenex HFA) 2 inhalations
❑ Pirbuterol (Maxair) 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).

❑ EpiPen® 0.3 mg
❑ EpiPen® Jr. 0.15 mg
❑ Auvi-Q™ 0.3 mg
❑ Auvi-Q™ 0.15 mg
❑ Adrenaclick® 0.3 mg
❑ Adrenaclick® 0.15 mg

❑ May carry & self-administer epinephrine 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 symptoms of anaphylaxis in an emergency room**
- **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 a medical history of asthma and/or anaphylaxis and the use of the above-listed medication(s) has been reviewed by the HCP. If medications are self-administered, the school staff **must** be notified.

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

Heath Care Provider name: *(please print)* _____ **Phone:** _____

Health Care Provider signature: _____ **Date:** _____

Parent signature: _____ **Date:** _____

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

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