

The Student Asthma/Allergy Action Plan has some important updates:

- There have been some updates to the language in the interest of health literacy as our understanding and knowledge continues to grow.
- Medications have been updated to reflect what is currently on the market.
- There is a **new** check box and line for a physician to check which instructs administration of epinephrine immediately upon ingestion of a known allergen.
- The check box for a student to self-carry and self-administer their medication **MUST NOW BE CHECKED** if you are in agreement with the parent that this is something the student is capable of and that they have demonstrated correct use of their prescribed medications.

The Student Asthma/Allergy Action Plan has two pages:

- Page 1 is for the physician to complete and sign.
Physicians—please give your patients BOTH sides or let them know to ask the school for the second page.
- Page 2 is for the parent/caregiver to complete and sign.

In order for the school to have all the information needed, both pages should be completed and presented to the school along with prescribed medications.

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 valved holding chamber
- May carry & self-administer inhaler (MDI)
- 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
- 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 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

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 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 (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 for Students Requiring Special Meals".

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: _____