STUDENT ASTHMA/ANAPHYLAXIS ACTION PLAN

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

❑ Twinject™ 0.3 mg
❑ Twinject™ 0.15 mg

❑ Adrenaclick® 0.3 mg
❑ Adrenaclick® 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/ANAPHYLAXIS INFORMATION

(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 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, your 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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