

STUDENT ASTHMA/ANAPHYLAXIS ACTION PLAN

STUDENT NAME: _____ DATE OF BIRTH _____ / _____ / _____
(MONTH) (DAY) (YEAR)

EXERCISE PRECAUTION: Administer inhaler (**2 inhalations**) 15-30 minutes before exercise (e.g., gym class, recess).

- | | |
|--|---|
| <input type="checkbox"/> Albuterol inhaler (Proventil, Ventolin) | <input type="checkbox"/> Use inhaler with spacer device: _____ |
| <input type="checkbox"/> Levalbuterol (Xopenex HFA) | <input type="checkbox"/> May carry and self-administer metered-dose inhaler |
| <input type="checkbox"/> Pirbuterol inhaler (Maxair) | <input type="checkbox"/> Other: _____ |

ASTHMA TREATMENT

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

- Albuterol inhaler (Proventil, Ventolin) 2 inhalations.
- Levalbuterol (Xopenex HFA) 2 inhalations.
- Use inhaler with spacer device: _____
- Pirbuterol inhaler (Maxair) 2 inhalations.
- Albuterol inhaled **by nebulizer** (Proventil, Ventolin, AccuNeb).
 - 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: _____
- May carry and self administer metered dose inhaler.

CLOSELY OBSERVE THE STUDENT AFTER GIVING QUICK RELIEF ASTHMA MEDICATIONS

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).**

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).

- Epinephrine injection (please specify):
 - EpiPen 0.3 mg 2-Pak Twinject 0.3 mg
 - EpiPen Jr. 0.15 mg 2-Pak Twinject 0.15 mg
- Other: _____
- May carry and self-administer epinephrine injection.

CALL 911 AND CLOSELY OBSERVE THE STUDENT AFTER GIVING EPINEPHRINE

- 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).**

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 _____

Physician name (please print) _____ Phone _____

Physician signature _____ Date _____

Parent signature _____ Date _____

Reviewed by school nurse/ nurse designee _____ Date _____

Asthma/Allergy Action Plan

This page to be completed by Parent/Guardian

Name _____ Age _____ Grade _____

School _____ Teacher _____

Parents/Guardian _____ Phone(H) _____ (W) _____

Parents/Guardian _____ Phone(H) _____ (W) _____

Alternate Emergency Contact _____ Phone(H) _____ (W) _____

Alternate Emergency Contact _____ Phone(H) _____ (W) _____

KNOWN ASTHMA TRIGGERS Please check those that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Odors/fumes/smoke | <input type="checkbox"/> Respiratory/viral infections |
| <input type="checkbox"/> Mold/mildew | <input type="checkbox"/> Pesticides | <input type="checkbox"/> Cold air |
| <input type="checkbox"/> Pollens | <input type="checkbox"/> Emotions | <input type="checkbox"/> Temperature/weather changes |
| <input type="checkbox"/> Animals/Animal dander | <input type="checkbox"/> Grasses/trees | <input type="checkbox"/> Dust/dust mites |
| <input type="checkbox"/> Other, specify _____ | | |

ALLERGY/INTOLERANCE Please check those that apply

- | <u>Item</u> | |
|---------------|--------------------------|
| Peanuts | <input type="checkbox"/> |
| Tree nuts | <input type="checkbox"/> |
| Fish | <input type="checkbox"/> |
| Shellfish | <input type="checkbox"/> |
| Eggs | <input type="checkbox"/> |
| Soy | <input type="checkbox"/> |
| Wheat | <input type="checkbox"/> |
| Milk | <input type="checkbox"/> |
| Latex | <input type="checkbox"/> |
| Insect stings | <input type="checkbox"/> |
| Other _____ | <input type="checkbox"/> |

NOTICE

If your child requires a special diet to limit or eliminate foods to which he/she is allergic/intolerant, please have his/her physician write an order for the diet and return it to the school nurse.

Please describe the type of reaction your child typically experiences if he/she comes in contact with the item/s to which he/she is allergic/intolerant.

MEDICATIONS

Routine non-emergency medications used at home or school:

<u>Name</u>	<u>Dose</u>	<u>Frequency</u>
-------------	-------------	------------------

1. _____

2. _____

3. _____

PARENT AUTHORIZATION

I have reviewed and approve of this Action Plan. I understand school personnel will follow this plan and if necessary, will call 911 and use the Protocol.

Parent Signature

Date

SCHOOL NURSE APPROVAL

I have reviewed and approve of this Action Plan.

School Nurse/Nurse Designee Signature

Date