

# Student Asthma/Allergy Action Plan

(This Page To Be Completed By Health Care Provider)

Student Name: \_\_\_\_\_ Weight: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(MONTH) (DAY) (YEAR)

- ☐ **Exercise Pre-Treatment:** Administer inhaler (**2 inhalations**) 15-30 minutes prior to exercise. ☐ PE ☐ Recess
- ☐ Albuterol /Levalbuterol HFA inhaler (Proventil, Ventolin, ProAir, Xopenex) ☐ Use inhaler with valved holding chamber
- ☐ Albuterol DPI (ProAir RespiClick) ☐ May carry & self-administer quick relief medication

## Asthma Treatment

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

- ☐ Albuterol /Levalbuterol HFA - 2-4 inhalations  
(Proventil, Ventolin, ProAir, Xopenex)
- ☐ Use inhaler with valved holding chamber
- ☐ Albuterol DPI (ProAir RespiClick) - 2 inhalations
- ☐ 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 quick relief medication

**If symptoms do not improve, quick relief medication can be repeated after 10 minutes**

### 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

**If student continues to get worse, CALL 911 & 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, with difficulty breathing (chest or neck "sucking in"), lips or fingernails turning blue, or trouble talking (shortness of breath) or vomiting or collapse.

- ☐ EpiPen® 0.3 mg ☐ EpiPen® Jr 0.15 mg
- ☐ AUVI-Q® 0.3 mg ☐ AUVI-Q® Jr. 0.15 mg
- ☐ AUVI-q® 0.1 mg

☐ Other: \_\_\_\_\_

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

- ☐ **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**
- ☐ May carry & self-administer epi auto-injector

### **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:** \_\_\_\_\_

# 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](http://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: \_\_\_\_\_