

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 health care providers to check which instructs administration of epinephrine immediately upon ingestion of a known allergen.
- ⇒ The check box stating that you have reviewed the use of medications in order for a student to self-manage at school **MUST NOW BE CHECKED.**

The Student Asthma/Allergy Action Plan has two pages:

- Page 1 is for the physician to complete and sign.
Health Care Providers—please give your patients **BOTH pages!**
- Page 2 is for the parent/caregiver to complete and sign.
- **This action plan is only valid for students in K-12 grades.** If they are younger or older, please use a different action plan.

EMPHASIZE THE FOLLOWING TO YOUR FAMILIES AND PATIENTS!

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

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) _____

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

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: _____