ATTACK ON ASTHMA
NEBRASKA

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).

- ❑ Albuterol inhaler (Proventil, Ventolin)
- ❑ Levalbuterol (Xopenex HFA)
- ❑ Pirbuterol inhaler (Maxair)
- ❑ Use inhaler with spacer device:_____
- ❑ May carry and self-administer metered-dose inhaler
- ❑ 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**_____

For additional copies and references, go to http://www.attackonasthma.org

Version: 8/21/06

Plan For _____ **(Student) Dated:** _____

ASTHMA OR ANAPHYLAXIS MEDICAL MANAGEMENT PLAN

I. CONTACT AND PLAN INFORMATION

Student's Name: _____ **Date of Birth:** _____/___/_____
(Month) (Day) (Year)

Health Condition: ☐ Asthma ☐ Anaphylaxis (For *this Plan "Health Condition" means the condition(s) checked)*

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell_____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider:_____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts:_____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

II. PARENT OR GUARDIAN AUTHORIZATION, APPROVAL AND LIABILITY WAIVER

The parents or guardians (hereinafter "Parent") request that School allows the Student to self-manage the health condition and accept and agree to this Medical Management Plan. The Guidelines for Asthma or Anaphylaxis Medical Management Plan are incorporated into and are a part of this Plan.

Parents understand and agree that if the Student injures school personnel or another student as the result of the misuse of necessary asthma or anaphylaxis medical supplies, Parents shall be responsible for any and all costs associated with such injury. Parents acknowledge that (a) the school and its employees and agents are not liable for any injury or death arising from the Student's self-management of the Student's Health Condition and Parents release same from any such claims and (b) Parents shall and do hereby agree to indemnify and hold harmless the school and its employees and agents against any claim arising from the Student's self-management of Student's Health Condition. This release, indemnification and hold harmless agreement shall take effect immediately and shall stay in effect for as long as the Student is provided permission to self-administer medication.

Parent/guardian signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

III. STUDENT AGREEMENT

I will use the prescription asthma or anaphylaxis medication only as prescribed and as permitted by the Plan. I will not share the medication with others and I will not create an unnecessary distraction to others. I have been instructed how to self-administer this medication and understand the side effects of improper use and will promptly report self-administration and follow the Guidelines. I understand that if I do not abide by these terms, I may be disciplined and that this Plan will be re-evaluated. I release the school and its employees of any liability any in way related to this Plan or my use of the medication.

Student signature: _____ Date: _____