Student Asthma/Allergy Action Plan

(This Page To Be Completed By Physician)

Student Name: _____ **Date Of Birth:** ____/____/____ (MONTH) (DATE) (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 (MD)
☐ Other: _____

Asthma Treatment

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

☐ Abuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
☐ Levalbuterol (Xopenex HFA) 2 inhalations
☐ Pirbuterol (Maxair) 2 inhalations
☐ Use inhaler with spacer/valved holding chamber
☐ May cary & self-administer inhaler (MD)
☐ 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)
☐ 0.3 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 <u>after</u> notifying parent/guardian
- No improvement in symptoms, repeat the treatment and notify parent/guardian immediately
- ***<u>If student continues to worsen CALL 911 and Initiate the Richmond County Schools' Emergency Response to LifeThreatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol</u>***

Anaphylaxis Treatment

Give **epinephrine** when student experiences allergy Symptoms, such as tongue swelling, throat closing, change in voice, faintness, 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 <u>After</u>* Giving Epinephrine, Closely Observe the Student**

- Notify parent/guardian immediately
- ***<u>Even</u>* If student improves, the student *Should be observed for recurrent Symptoms of anaphylaxis in an emergency medical facility***
- ***<u>If student does not improve or continues to worsen,consider a second dose of epinephrine and initiate Life Threatening Allergic Reaction Protocol</u>***

☒ 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 <u>must</u> be notified.

<u>Additional information:</u> *(i.e asthma triggers, allergens)* _____

_____

Physician name: *(please print)* _____ **Phone:** _____

Physician Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____

Reviewed by school nurse/nurse designee: _____ **Date:** _____

Authorization for Student to Carry a Prescription
Inhaler, EpiPen® or Insulin

_____needs to carry the following prescription labeled inhaler, EpiPen® or insulin with him/her. The above named student has been instructed in the proper use of the medication and fully understands how to administer this medication. (It is preferable that a second prescription labeled inhaler, EpiPen® or additional insulin be kept in the clinic in case the first is lost or left at home.)

Medication Dosage and Directions

Physician's Signature or Stamp Date

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I have been instructed in the proper use of my prescription labeled medication and fully understand how to administer this medication. I will not allow another student to use my medication under any circumstances. I also understand that should another student use my prescription, the privilege of carrying my medication may be revoked. I also accept the responsibility for checking in with the school nurse to keep her informed of use of my medication in case I start having problems.

Student's Signature Date

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I hereby request that the above named student, over whom I have legal control, be allowed to carry and use the prescription medication described above, at school. I accept legal responsibility should the above medication be lost, given or taken by a person other than the above named student. I understand that if this should happen, the privilege of carrying the medication may be revoked. I release the _____school district and its employees of
Any legal responsibility when the above named student administers his/her own medication.

Parent/Guardian Signature Date