Student Asthma/Allergy Action Plan

Richmond County School System

(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 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 Richmond County Schools' Emergency Response to LifeThreatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol***

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 After Giving Epinephrine, Closely Observe the Student

- 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, consider a second dose of epinephrine and initiate Life Threatening Allergic Reaction Protocol***

☒ 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: *(i.e asthma triggers, allergens)* _____

_____

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

Physician Signature: X _____ **Date:** _____

Parent Signature: X _____ **Date:** _____

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

* Dr. & Parent Signatures required *

→

Richmond County School System

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Parent/Guardian)

Student Name: _____ Age: _____ Grade: _____

School: _____ Homeroom Teacher: _____

Parent/Guardian: _____ Phone(H) _____ (W) _____

Parent/Guardian: _____ Phone(H) _____ (W) _____

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

Know Asthma Triggers: Please check the boxes to identify what can cause an asthma episode for your student.

- ☐ Exercise
- ☐ Respiratory/viral infections
- ☐ Odors/fumes/smoke
- ☐ Mold/mildew
- ☐ Pollens
- ☐ Animals/dander
- ☐ Dust/dust mites
- ☐ Grasses/trees
- ☐ Temperature/weather – humidity, cold air, etc.
- ☐ Pesticides
- ☐ Food – Please list below
- ☐ Other- please list: _____

Know Allergy/Intolerance: Please check those which apply and describe what happens when your child eats or comes into contact with the allergen.

- Peanuts ☐ _____
- Tree Nuts ☐ _____
- Fish/Shellfish ☐ _____
- Eggs ☐ _____
- Soy ☐ _____
- Wheat ☐ _____
- Milk ☐ _____
- Medication ☐ _____
- Latex ☐ _____
- Insect stings ☐ _____
- Other ☐ _____

Notice : If your child has been prescribed epinephrine (e.g. EpiPen) for an allergy, it is also necessary to provide epinephrine at school. If your student requires a special diet to limit or eliminate foods, your school may ask your physician to complete the form *"Medical Statement for Students Requiring special Meals"*.

Daily Medications: Please list daily medications used at home and/or to be administered at school.

Medication Name	Amount/Dose	When administered

I understand that all medications to be administered at school must be provided by the parent/guardian.

Parent signature: X _____ Date: _____

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