Humphrey Public Schools

Phone: 402-923-1230 FAX: 402-923-1235

Dear Parents,

Information at the school indicates that your child, _____, has asthma or a severe allergy.

Please have the attached Student Asthma/Allergy Action Plan (page 1) completed by the student's physician. The physician's signature **needs to be present** at the bottom of page 1. Page 2 can be filled out by the parent. This information will be filed for reference at school.

I will be at Humphrey Public Schools once a month. If you have any questions, please contact me at twondercheck@esu8.org.

Sincerely,

Teresa Wondercheck, RN

ESU8 School Nurse

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 toget 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:** _____

Version: 06/18

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.

- ❑ 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: _____

Known 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 (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*

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:** _____