Students with Asthma

Attached you will find 2 forms that will need to be filled out and signed.

1. Asthma action plan take with you to the student's physical appointment and the Dr. can fill it out and sign it for you.
2. Release and indemnification agreement must be signed and turned in before the first day of school.

For more information see Asthma Self-administration in the Student Handbook located on the Scotus web site, scotuscc.org , under publications, student handbook.

If you have ANY questions please give me a call or email me.

Sincerely

Laurie L. Hergott

402-564-7165 Ext 103

lhergott@scotuscc.org

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)
❑ Albuterol DPI (ProAir RespiClick)
❑ Levalbuterol (Xopenex HFA)
❑ 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
❑ Albuterol DPI (ProAir RespiClick) 2 inhalations
❑ Levalbuterol (Xopenex HFA) 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® Jr. 0.15 mg

❑ Other: ________________________________

❑ May carry & self-administer epi 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 signs/ symptoms of anaphylaxis in an emergency facility**
- **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 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:** ________________

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:** ____________

RELEASE AND INDEMNIFICATION AGREEMENT
(Self-Administration of Prescription Asthma or Anaphylaxis Medication)

I,______________________________ hereby acknowledge that Scotus Central Catholic, including its employees and agents ("School") is not liable for any injury or death arising out of the self-management by ___________________ of his/her asthma or anaphylaxis condition and I hereby indemnify and hold School from any claim arising from the student's self-Management. In the event that ______________________ injures school Personnel or another student as a result of misuse of the prescription asthma or anaphylaxis medication or related medical supplies, the undersigned shall be responsible for any and all costs associated with the injury.

____
Date

____
Parent or Guardian