ASTHMA and/or ALLERGY ACTION PLAN (Complete ONLY if necessary)

(to be completed by child's health care provider)

Student Name:_____ Date of Birth _____ Grade _____

Check applicable box:

☐ My child requires an Asthma Action Plan
☐ My child requires an Allergy Action Plan (see reverse side)

ASTHMA ACTION PLAN

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms

Please list known asthma triggers: _____

Medication(s) to be given for asthma control (to be completed by child's health care provider):

NAME OF MEDICATION	STRENGTH	DOSE	ROUTE (circle)	FREQUENCY (include minimum time interval for prn dosing)
			Tablet/Capsule/Liquid (oral) Inhaler/Nebulizer, Other_____	_____ OR as needed every _____ hours
			Tablet/Capsule/Liquid (oral) Inhaler/Nebulizer, Other_____	_____ OR as needed every _____ hours
			Tablet/Capsule/Liquid (oral) Inhaler/Nebulizer, Other_____	_____ OR as needed every _____ hours
			Tablet/Capsule/Liquid (oral) Inhaler/Nebulizer, Other_____	_____ OR as needed every _____ hours

☐ Yes ☐ No Is student capable and responsible for self-administering this medication?
☐ Yes ☐ No May student carry inhaler?

If an asthma attack occurs while on this trip, school personnel should follow the plan below:

1. _____
2. _____
3. _____
4. _____

Procedures to follow if student is unable to administer the medication, or if it does not produce the expected relief from student's asthma attack: _____

_____

Other special instructions: _____

HEALTH CARE PROVIDER SIGNATURE: _____ Date _____

Health Care Provider (printed)_____

Address_____ Phone & Fax Numbers: _____

PARENT/GUARDIAN SIGNATURE: I understand that if symptoms are not relieved by the steps taken above and indicate the need for emergency care, school personnel will call for emergency services. If my child self-administers medication, it is my responsibility to review with my child when he/she should seek additional medical assistance.

Parent/Guardian Signature: _____ Date _____

ALLERGY ACTION PLAN

For allergies requiring possible emergency treatment

Please list known allergies: _____

Medication(s) to be given for allergy control (to be completed by child's health care provider):

Important: ***Asthma inhalers and/or antihistamines cannot be depended upon to replace epinephrine in anaphylaxis.***

Emergency Calls: If epinephrine is given to the child, paramedics (911) will be called. School Personnel will state that an anaphylactic reaction has been treated; the type of treatment given (i.e., Epi-pen or Auvi-Q); and that additional epinephrine may be needed. The empty autoinjector will be sent to ER with student.

NAME OF MEDICATION	STRENGTH	DOSE	ROUTE (circle)	FREQUENCY (include minimum time interval for prn dosing)
			Tablet/Capsule/Liquid (oral) Inhaler/Nebulizer, Other_____	_____ OR as needed every _____ hours
			Tablet/Capsule/Liquid (oral) Inhaler/Nebulizer, Other_____	_____ OR as needed every _____ hours
			Tablet/Capsule/Liquid (oral) Inhaler/Nebulizer, Other_____	_____ OR as needed every _____ hours

Treatment Plan

Symptoms		**Give Circled Medication**	
If a food item has been ingested, but *no symptoms*:		Epinephrine	Antihistamine
Mouth:	Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
Skin:	Hives, itchy rash, swelling of face or extremities	Epinephrine	Antihistamine
Gut:	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
*Throat**:	Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
*Lung**:	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
*Heart**:	Thready pulse, low BP, fainting, pale, blueness	Epinephrine	Antihistamine
If reaction is progressing (several of the above areas affected) give:		Epinephrine	Antihistamine
Other*_____:		Epinephrine	Antihistamine

The severity of symptoms can quickly change. **potentially life threatening*

☐ Yes ☐ No Is student capable and responsible for self-administering this medication?

☐ Yes ☐ No May student carry epinephrine?

Procedures to follow if student is unable to administer the medication, or if it does not produce the expected relief from student's allergic reaction: _____

_____

Other special instructions: _____

HEALTH CARE PROVIDER SIGNATURE: _____ Date _____

Health Care Provider (printed)_____

Address_____ Phone & Fax Numbers: _____

PARENT/GUARDIAN SIGNATURE: I understand that if symptoms are not relieved by steps taken above and indicate the need for emergency care, school personnel will call for emergency services. If my child self-administers medication, it is my responsibility to review with my child when he/she should seek additional medical assistance. I understand that I will provide two Epi-pens for the trip.

Parent/Guardian Signature: _____ Date _____