ARLINGTON PUBLIC SCHOOLS' SELF-MANAGEMENT OF ASTHMA & SEVERE ALLERGY (ANAPHYLASIS) AT SCHOOL CONSENT/RELEASE FORM

Parental consent/release in writing is required annually and must be accompanied by:

- **Signed physician authorization for self-management of asthma/anaphylaxis at school.**
- **Current written 'Student Asthma/Allergy Action Plan'. The school can provide a form for your use.**
- **We strongly recommend you allow us to keep an extra supply of your child's medication at school.**

PARENT/GUARDIAN: By signing below, you acknowledge the following:

1. You are requesting that your student be allowed to self-manage his or her asthma or allergy condition at school.
2. You have confidence that your student has the knowledge and skills needed to self-manage his or her asthma or allergy condition at school.
3. You understand that you are not required to make this request on behalf of your child. Your child may utilize the health office for asthma and allergy cares. Your child may request assistance from qualified school health personnel at any time during the school day.
4. If your student injures school personnel or another student as a result of misuse of asthma or allergy supplies, you shall be responsible for any and all cost associated with such injury.
5. The school and its employees are not liable for any injury or death arising from a student's self-management of his or her asthma or allergy condition.
6. You will indemnify and hold harmless the school and its employees and agents against any claim arising from a student's self-management of his or her asthma or allergy.

_____ _____

Parent/Guardian Printed Name Student Printed Name

_____ _____

Parent/Guardian Signature Date

THIS PORTION RECOMMENDED, NOT REQUIRED

STUDENT: By signing below, you agree that you understand:

1. You must not share, or allow another student to handle, your medications or supplies.
2. You will notify the school nurse or other designated adult when you have used your medication.
3. If you don't feel better after using your medication, you will seek help from school personnel.

_____ _____

Student Printed Name Date

_____

Student Signature

Reference: Neb.Rev.Stat. 79-224 (2006)

ARLINGTON PUBLIC SCHOOLS
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:** Administrator 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 valved holding chamber
- ☐ Other: _____

ASTHMA TREATMENT

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

- ☐ Albutero HFA (Proventil, Ventolin, ProAir) **2 inhalations**
- ☐ Levalbuterol (Xopenex HFA) **2 inhalations**
- ☐ Pirbuterol (Maxair) **2 inhalations**
- ☐ Use inhaler with valved holding chamber
- ☐ Albutero 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 and 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 Protocal**

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).

- ☐ Epi Pen® 0.3 mg
- ☐ EpiPen®Jr. 0.15 mg
- ☐ Auvi-Q™ 0.3 mg
- ☐ Auvi-Q™ 0.15 mg
- ☐ Adrenaclick® 0.3 mg
- ☐ Adrenaclick® 0.15 mg

- ☐ May carry and self-administer epinephrine 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 having difficulty breathing, let them lie on their side.

***CALL 911* After Giving Epinephrine and Closely Watch The Student**

- Notify parent/guardian immediately
- **Even if student gets better, the student should be watched for more symptoms of anaphylaxis in an emergency room**
- **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) Protocal**

☐ This student has a medical history of asthma and/or anaphylaxis and the use of the above-listed medication(s) has been reviewed by the HCP. If medications are self-administered, the school staff **must** be notified.

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:** _____

ARLINGTON PUBLIC SCHOOLS'
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	☐ Dust/Dust Mites	☐ Others-please list:_____
☐ Respiratory/Viral Infections	☐ Grasses/Trees	_____
☐ Odors/Fumes/Smoke	☐ Temperature/Weather-Humidity, Cold Air, etc.,	_____
☐ Mold/Mildew		_____
☐ Pollens	☐ Pesticides	_____
☐ Animals/Dander	☐ Food-Please list below.	

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

Daily Medicines: Please list daily medicines used at home and/or to be given at school.

Medicine Name	**Amount/Dose**	**When does it need to 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:** _____

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