Plan For _____ **(Student) Dated:** _____

ASTHMA OR ANAPHYLAXIS MEDICAL MANAGEMENT PLAN

I. CONTACT AND PLAN INFORMATION

Student's Name: _____ **Date of Birth:** ____/____/____
(Month) (Day) (Year)

Health Condition: ☐ Asthma ☐ Anaphylaxis (For *this Plan "Health Condition" means the condition(s) checked)*

Mother/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Father/Guardian: _____

Address: _____

Telephone: Home _____ Work _____ Cell _____

Student's Doctor/Health Care Provider: _____

Address: _____

Telephone: _____ Emergency Number: _____

Other Emergency Contacts: _____

Relationship: _____

Telephone: Home _____ Work _____ Cell _____

II. PARENT OR GUARDIAN AUTHORIZATION, APPROVAL AND LIABILITY WAIVER

The parents or guardians (hereinafter "Parent") request that Elmwood-Murdock Public Schools allow the Student to self-manage the health condition and accept and agree to this Medical Management Plan. The Guidelines for Asthma or Anaphylaxis Medical Management Plan are incorporated into and are a part of this Plan.

Parents understand and agree that if the Student injures school personnel or another student as the result of the misuse of necessary asthma or anaphylaxis medical supplies, Parents shall be responsible for any and all costs associated with such injury. Parents acknowledge that (a) the school and its employees and agents are not liable for any injury or death arising from the Student's self-management of the Student's Health Condition and Parents release same from any such claims and (b) Parents shall and do hereby agree to indemnify and hold harmless the school and its employees and agents against any claim arising from the Student's self-management of Student's Health Condition. This release, indemnification and hold harmless agreement shall take effect immediately and shall stay in effect for as long as the Student is provided permission to self-administer medication.

Parent/guardian signature: _____ Date: _____

Parent/guardian signature: _____ Date: _____

III. STUDENT AGREEMENT

I will use the prescription asthma or anaphylaxis medication only as prescribed and as permitted by the Plan. I will not share the medication with others and I will not create an unnecessary distraction to others. I have been instructed how to self-administer this medication and understand the side effects of improper use and will promptly report self-administration and follow the Guidelines. I understand that if I do not abide by these terms, I may be disciplined and that this Plan will be re-evaluated. I release the school and its employees of any liability in any way related to this Plan or my use of the medication.

Student signature: _____ Date: _____

F. Student Asthma/Anaphylaxis Action Plan

Student Name: _____ **Date of Birth:** ____/____/____
(Month) (Day) (Year)

EXERCISE PRECAUTION - Administer inhaler 15-30 minutes before exercise (eg, gym class, recess)

☐ Albuterol inhaler (Proventil, Ventolin) 2 inhalations

ASTHMA TREATMENT

Give or self-administer ***quick relief medication*** when Student experiences asthma symptoms such as, coughing, wheezing, or tight chest.

Quick relief medication:

☐ Albuterol inhaler (Proventil, Ventolin) 2 inhalations

☐ Pirbuterol inhaler (Maxair) 2 inhalations

☐ Albuterol inhaled *by nebulizer* (Proventil, Ventolin)

- ☐ 0.63 mg/3 mL
- ☐ 1.25 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 metered-dose inhaler per Part IV(B) of Medical Management Plan.

IF SCHOOL STAFF INVOLVED-- CLOSELY OBSERVE STUDENT AFTER QUICK RELIEF ASTHMA MEDICATION IS ADMINISTERED

If after 10 minutes:

- Symptoms are improved, student may return to classroom after notifying parent/guardian.
- If no improvement in symptoms, repeat the above medication and notify parent/guardian immediately and determine student's ability to remain in school for the day.
- ***If student continues to worsen*** **CALL 911 and INITIATE Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions Protocol (Asthma).**

ANAPHYLAXIS TREATMENT

Give or self-administer ***epinephrine*** when Student experiences allergy symptoms, such as hives, difficulty breathing (chest or neck "sucking in"), lips or fingernails turning blue, or trouble talking (shortness of breath).

□ The Student has severe allergies to the following:

_____

□ Epinephrine injection (please specify):

- □ EpiPen 0.3 mg
- □ Twinject 0.3 mg
- □ EpiPen Jr. 0.15 mg
- □ Twinject 0.15 mg

□ May carry and self-administer epinephrine injection per Part IV(B) Medical Management Plan.

IF SCHOOL STAFF INVOLVED--CLOSELY OBSERVE STUDENT AFTER EPINEPHRINE IS ADMINISTERED

- ***CALL 911*** **and 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*, INITIATE Nebraska's schools Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions Protocol (Anaphylaxis).

Possible adverse reactions to be reported to physician _____

_____

Special instructions _____

I am the Student's Physician. Student has ☐ Asthma ☐Anaphylaxis and has been prescribed the medication referenced above. Student has the ability to safely and responsibly self-manage Student's Health Condition in accordance with this Asthma or Anaphylaxis Medical Management Plan. I approve the Medical Management Plan and the Student Asthma/Anaphylaxis Action Plan and authorize Student to self-manage Student's Health Condition at school in accordance with the Plan.

Physician signature: _____ Date: _____

Student's person so the Student is not reported for a violation of the school's drug policies). The school officials who may be informed of the Plan thus include: administration, school nurse, school office staff, teachers and any paraeducators or specialists who provide services to the Student, and the coaches and sponsors of extracurricular activities in which the Student participates.

Filing of Plan: This Asthma or Anaphylaxis Medical Management Plan is to be kept on file at the school where the Student is enrolled.

VI. SCHOOL NURSE ACKNOWLEDGEMENT OF ASTHMA OR ANAPHYLAXIS MEDICAL MANAGEMENT PLAN

☐ Parent Request and Liability Waiver signed ☐ Student Agreement signed.

☐ Management Plan (including Action Plan) signed by Physician.

☐ Guidelines reviewed with the Student and Parent/Guardian.

☐ Copy of Guidelines and Student Agreement received by Parent/Guardian for reference.

School Nurse or designee signature: _____ Date: _____