

IHP/EAP for Student with Asthma/Anaphylaxis

Name: _____ Date of Birth: _____

Parent/Guardian: _____

Phone: (w) _____ (h) _____ (c) _____ Phone: (w) _____ (h) _____ (c) _____

Healthcare Provider: _____ Phone: _____ Fax: _____

Asthma Severity:

- ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
☐ Student has had many or severe asthma attacks/exacerbations

Triggers which may start an asthma episode. Check all that apply

- | | | |
|---|--|--|
| ☐ Exercise | ☐ Change in temperature | ☐ Mold |
| ☐ Strong odors or fumes | ☐ Animals | ☐ Foods: _____ |
| ☐ Respiratory infections | ☐ Pollens | ☐ Others: _____ |

Allergy to: _____ Date of last anaphylaxis episode & treatment: _____

Other pertinent history of student's condition: _____

Control of School Environment

List any environmental control measures, pre-medications, and/or dietary restrictions to prevent an episode: _____

Medication Plan

_____ Student uses an aerochamber or spacer with inhaler

Medication Name	Amount/Dose	When should it be given

Exercise/Physical Education/Recess Plan:

- | | |
|--|---|
| ☐ Use inhaler before PE, then participate normally. | ☐ Use inhaler before exercise/activity, attempt moderate participation with frequent walking. |
| ☐ Use inhaler before recess, then participate normally. | ☐ Not to participate in extensive running (mile run, pacer fitness run, 12-minute timed run, etc) but will walk instead. |
| ☐ Use inhaler PRN. | ☐ Other: _____ |

Asthma Emergency Plan

Administer quick relief medication for symptoms: coughing, wheezing, difficulty breathing, or tight chest.

Other symptoms: _____

- ☐ Albuterol/Levalbuterol _____ inhalations
☐ Other: _____

After 10 minutes:

- ☐ Symptoms are improved, student may return to the classroom after parent/guardian is notified.
☐ Symptoms are **NOT** improved, repeat quick relief medication and contact parent/guardian.

If student's condition continues to worsen, call 911 and initiate Rule 59 protocol.

Anaphylaxis Emergency Plan

Administer epinephrine for allergy symptoms: hives with difficulty breathing (chest or neck pulled in), blue lips or fingernails, shortness of breath, vomiting or collapse.

Other symptoms: _____

Administer:

- ☐ EpiPen Jr (0.15mg) ☐ EpiPen (0.3mg)
☐ Auvi-Q _____ ☐ Other: _____

Call 911 and contact parent/guardian immediately.

If student's condition continues to worsen before emergency personnel arrive, initiate Rule 59 protocol.

Student needs to be transported to an emergency facility, even if symptoms have improved.

IHP/EAP for Student with Asthma/Anaphylaxis

Healthcare Provider Consent for Asthma/Anaphylaxis Management

I have reviewed and approved this management plan and included any recommended modifications. This consent is for a maximum of one year. If changes in procedure are indicated, I will provide written orders accordingly. I have instructed this student in the proper use of his/her medications and the student:

- ☐ should keep medications in the nurse's office.
- ☐ should be allowed to carry and administer medications by himself/herself and should report event to the nurse any time after self administering.

Healthcare Provider Signature

Date

Parent Consent for Asthma/Anaphylaxis Management

I, as parent/guardian, concur with the above management plan, will provide the necessary supplies and equipment, notify the school nurse if there is any change in my child's health status or doctor's orders, and authorize the school nurse to contact the physician when necessary.

- ☐ I request that my child's medication be kept and administered in the nurse's office.
- ☐ I give permission for my child to self-administer medication for asthma as prescribed by their physician and/or as written in their individual healthcare plan (IHP). This self management plan will be in effect until rescinded by either party.
 - ☐ I hereby certify that my child has been fully instructed and is capable of self-administration of the medication. I consent to my child carrying, storing and self-administering the medication at school. I acknowledge that I am responsible for providing my child with the medication, properly labeled from the pharmacy, and that I am responsible for any and all monitoring of my child's use of the medication and for any and all consequences of my child's self-administration of medication at school. I will indemnify and hold harmless Grand Island Public Schools, its employees and agents, against any and all claims arising out of my child's self-administration of medication at school, or at a school-related event.

Parent/Guardian Signature

Date

Student Consent for Self Management of Care

I will not share or allow other students to handle my medications or supplies.
I will notify the school nurse or other designated adult when I use my medication.
I will present to the nurse's office or designated adult if further medical care is needed.

Student Signature

Date