USD #475 Asthma Action Plan

Student Name____ DOB ________________

Parent/Guardian Name ____________________________________ Phone________________

Parent/Guardian Name ____________________________________ Phone ________________

Emergency Contact Name __________________________________ Phone________________

Primary Care Provider ____________________________________ Phone:________________

Daily Medication

This is the student's daily medicine plan:	
• The student has no asthma symptoms. • The student can do usual activities. • The student can sleep without symptoms	☐ Albuterol/Xopenex inhaler 2 puffs or 1 dosage nebulizer treatment every 4-6 hours **as needed** for wheezing/cough ☐ Albuterol/Xopenex inhaler 2 puffs or 1 dosage nebulizer treatment 15-20 minutes before exercise, **only if needed** ☐ ________________ ________________________ ☐ ________________ ________________________ ☐ ____

Asthma Emergency Plan – What to do for increased asthma symptoms

Do this **first** when asthma symptoms occur:	Have the student take rescue inhaler 2 puffs OR one nebulizer treatment every 20 minutes up to 3 times. This is a **test dose** to see if the student's asthma improves with Albuterol/Xopenex.
What to do next:	**When to do it:**
☐ Have the student return to the classroom ☐ Notify parents of students need for a quick relief medicine.	**Good Response to Test Dose of Albuterol/Xopenex** • The student's symptoms improve after 1-2 treatments. • The student no longer has symptoms (wheezing, coughing, shortness of breath, chest tightness.) • Student may continue Albuterol/Xopenex every 4 hours for 24-48 hours.
☐ Contact parent or guardian ☐ Contact the PCP for step-up medicine ☐ ________________	**Incomplete Response to Test Dose of Albuterol/Xopenex** • The student is experiencing mild to moderate symptoms (wheezing, coughing, shortness of breath, chest tightness) after taking 3 treatments. • The student cannot do normal school activities
☐ See emergency medical care in most locations, call 911 ☐ Call the PCP ________ ☐ ________________ ☐ NOTE: Wheezing may be absent because air cannot move out of the airways.	**Poor Response to Test Dose of Albuterol/Xopenex** • The student does not feel better 20-30 minutes after taking the rescue inhaler. • The student has severe symptoms (coughing, extreme shortness of breath, skin retractions between the ribs or at the neck). • The student has trouble walking or talking. • The student's lips or fingernails are blue. • The student is struggling to breathe.

Trigger List:

- ☐ Chalk Dust
- ☐ Cigarette Smoke
- ☐ Colds/Flu
- ☐ Dust or dust mites
- ☐ Stuffed animals
- ☐ Carpet
- ☐ Exercise
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests
- ☐ Pets
- ☐ Plants, flowers, cut grass, pollen
- ☐ Strong odors, perfume, cleaning products
- ☐ Sudden temperature change
- ☐ Wood smoke
- ☐ Foods: ________________ ________________
- ☐ Other: ________________ ________________

Health Care Provider Signature____________________________________ Date ____________

Parent Signature ____ Date____________

Health Care Provider Signature and Parent Signature required on both sides of form.

Emergency Action Plan – Anaphylaxis

Student Name____ DOB__________________

Team/Academy____ ID#__________________

Parent/Guardian Name ____ Phone__________________

Parent/Guardian Name____ Phone __________________

Emergency Contact Name ______________________________________ Phone __________________

Primary Care Provider ____ Phone __________________

Allergic to ____

Medication Prescribed

Epinephrine: Inject intramuscularly per manufacturer instructions (circle one) :

Twinject 0.3 mg   Twinject 0.15 mg   Epipen   Epipen, Jr

Other: ____

If above named students exhibits symptoms of anaphylaxis in response to allergen exposure, administer prescribed medication and call 911 immediately.

If new symptoms have appeared or symptoms have not improved within about 10 minutes of the first dose, a second dose of epinephrine is needed.

Symptoms of Anaphylaxis

Mouth	Itching, tingling or swelling of lips, tongue, mouth
Skin	Hives, itchy rash, swelling of the face or extremities
Gut	Nausea, abdominal cramps, vomiting, diarrhea
Throat	Tightening of throat, hoarseness, hacking cough, drooling,
Lung	Shortness of breath, repetitive cough, wheezing
Heart	Thready pulse, low blood pressure, fainting, pale, blueness
Other	____

The severity of symptoms can change quickly.

Additional Instructions ____

____

Health Care Provider Signature ____ **Date** ______________

Parent Signature ____ **Date** ______________

Health Care Provider Signature and Parent Signature required on both sides of form.

Emergency Action Plan- Allergy

Name______________________________ **Grade/Teacher** ______________ **DOB**__________

Allergic to:____

Name	Relationship	Home Phone	Cell/Work Phone

SYMPTOMS OF AN ALLERGIC REACTION MAY INCLUDE ANY/ALL OF THESE:

- MOUTH — Itching & swelling of lips, tongue or mouth, mouth "feels hot"
- THROAT — Itching, tightness in throat, hoarseness, cough
- SKIN — Hives, itchy rash, swelling of face and extremities
- STOMACH — Nausea, abdominal cramps, vomiting, diarrhea
- LUNG — Shortness of breath, repetitive cough, wheezing
- HEART — "thread pulse", "passing out"

The severity of symptoms can change quickly – it is important that treatment is given immediately

TREATMENT: Rinse area with water if appropriate

Benadryl ordered : __yes __no Give _______Benadryl per provider's order

Epinephrine ordered: __yes __no Give as ordered (special instructions______________________________)

Action Steps	Key Points
1. **When in doubt- give Epinephrine** 2. Call 911 3. Stay with victim 4. Calm and reassure victim 5. Repeat injection (Twinject) if after 10 minutes no better or has gotten better and begins having symptoms again 6. Note time Epinephrine given. Give Epinephrine injector to emergency personnel.	1. Avoid moving the victim unless necessary to avoid further exposure or dangerous situation 2. Epinephrine is injected through clothing 3. Victim may feel dizzy or heart "pounding" after receiving epinephrine- normal response 4. A second reaction may occur.

Additional information:____

School Nurse______________________________ Date_______________

At onset of a reaction initiate building emergency action plan.

Medical Statement to Request School Meal Modification

Important! Select the applicable meal modification category from the three listed below. Then carefully read and follow the procedures for that category. The school will return incomplete Medical Statements to the parent/guardian. If you have questions about this form, the school contact named in Part A below will assist you.

1. **Modification due to a disability:**
   - A school is required to make meal modifications prescribed by a licensed physician to accommodate a student's disability. See the definition of disability on the back of this form.
   - Part B of this form must be completed by a medical authority who is a licensed physician (MD or DO), physician's assistant (PA), advanced registered nurse practitioner (ARNP), or is authorized to write medical prescriptions under State Law.
   - Parts A and C of this form must also be completed before the school can make meal modifications.
   - The meal modifications will continue until a licensed physician requests that the modifications be changed or stopped on Form 19-C, which is available from the school.
   - It is strongly recommended that a licensed physician annually update the prescribed diet order.
2. **Modification due to a food allergy/intolerance, or other medical condition that does not rise to the level of a disability:**
   - A school has the option to make meal modifications prescribed by a medical authority due to a food allergy/intolerance or other medical condition that does not rise to the level of a disability.
   - Part B of this form must be completed by a medical authority who is a licensed physician (MD or DO), physician's assistant (PA), advanced registered nurse practitioner (ARNP), or is authorized to write medical prescriptions under State Law.
   - Parts A and C of this form must also be completed before the school can make meal modifications.
   - If a school chooses to make the meal modifications, they will continue until a medical authority requests that the modifications be changed or stopped on Form 19-C, which is available from the school.
   - It is strongly recommended that a medical authority annually update the prescribed diet order.
3. **Substitution for fluid cow's milk due to lactose intolerance, allergy, vegan diet, religious, ethical or cultural reasons:**
   - A school has the option to make a substitution for fluid cow's milk that is requested by a parent/guardian, but that is not prescribed by a medical authority. **USD 475 Does Not Have an appropriate substitute for milk at this time.**
   - Parts A and D of this form must be completed before the school can make a substitution for fluid cow's milk.
   - If a school chooses to provide such a substitution, they will continue until a parent/guardian requests that the substitution be changed or stopped on Form 19-C, which is available from the school.

Part A. Student, Parent/Guardian & School Contact Information – To be completed by a parent/guardian or school contact person		
Student's Name:	Date of Birth:	School:
Parent/Guardian's Name:	Parent/Guardian's Phone:	
School Contact's Name:	School Contact's Phone:	

Part B. Prescribed Diet Order – This part must be completed by a medical authority as specified above.

1. Check ONE:

   ☐ Disability OR ☐ Food allergy/intolerance or other medical condition that does not rise to the level of a disability

2. Specify the disability, food allergy/intolerance or medical condition related to the prescribed diet order.

3. If the student has a disability, what major life activity is affected? Example: Allergy to peanuts affects ability to breathe.

4. Type of Special Diet:

   ☐ Check if not applicable OR specify the type of special diet (e.g. low sodium, gluten-free, diabetic, etc.).

5. Modified Texture:	☐ Not Applicable	☐ Chopped	☐ Ground	☐ Pureed
6. Modified Thickness of Liquids:	☐ Not Applicable	☐ Nectar	☐ Honey	☐ Spoon or Pudding Thick

7. Special Feeding Equipment:
☐ Check if not applicable OR list special feeding equipment (e.g. large handled spoon, sippy cup, etc.).

8. Foods to be Omitted and Substituted:

☐ Check if not applicable OR list specific foods to be omitted and substituted. If more space is needed, sign and attach additional sheet of paper.

IMPORTANT: For a student who does not have a recognized disability, the only fluid cow's milk substitutions allowed by USDA are: (1) lactose-free fluid cow's milk or (2) a non-dairy beverage with a nutrient profile equivalent to fluid cow's milk as specified in federal regulations. Currently the only beverages meeting these specifications are certain brands of soymilk.

Omit Foods Listed Below:	Substitute Foods Listed Below:

9. Medical Authority's Information

Signature:	Title:	
Printed Name:	Phone:	Date:

Part C. Parent/Guardian Permission – To be completed by a parent/guardian

I give permission for school personnel responsible for implementing my child's prescribed diet order to discuss my child's special dietary accommodations with any appropriate school staff and to follow the prescribed diet order for my child's school meals. I also give permission for my child's medical authority to further clarify the prescribed diet order on this form if requested to do so by school personnel.

Parent/Guardian's Signature: Date:

Part D. Request Substitution for Fluid Cow's Milk due to Lactose Intolerance, Allergy, Vegan Diet, Religious, Cultural or Ethical Reasons – To be completed by a parent/guardian

Instead of fluid cow's milk, please provide the student named in Part A. of this form with the following substitute (Check ONE):

☐ Lactose-free cow's milk ☐ Non-dairy beverage with a nutrient profile equivalent to fluid cow's milk per federal regulations

Parent/Guardian's Signature: Date:

Definition of Disability:
Under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), a "person with a disability" means "any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment."

Major life activities covered by this definition include caring for one's self, eating, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, working and major bodily functions. The term "physical or mental impairment" includes, but is not limited to, such diseases, conditions, and functions as:

- Orthopedic, visual, speech and hearing impairments
- Cerebral Palsy, Epilepsy, Muscular Dystrophy and Multiple Sclerosis
- Digestive, bowel and bladder
- Neurological and brain
- Respiratory
- Cancer
- Cardiovascular, circulatory and heart
- Metabolic and endocrine
- Food anaphylaxis (severe food allergy)
- Mental retardation
- Emotional illness
- Drug addiction and alcoholism

Individuals who take mitigating measures to improve or control any of the conditions recognized as a disability are still considered to have a disability and require an accommodation.

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