ASTHMA ACTION PLAN

Name: ______________________________________

School:____________ **Grade:** ______ **Birthdate:** ___________________

TO BE COMPLETED BY HEALTH CARE PROVIDER

MEDICATION: ______________________________________

DOSAGE: ____

SIDE EFFECTS: ____________________________________

ADMINSTRATION

☐ With Spacer
☐ As Needed Every ___________ Hours
☐ 15 minutes prior to exercise if needed

GREEN ZONE	YELLOW ZONE	RED ZONE
Breathing is good No cough or wheeze Can work and play	Some problems breathing Cough, wheeze or chest tight Problems playing	Wheezing, Can't talk well Breathing hard and fast Nose opens when child breathes
Follow regular medication plan	Give _________ puffs of inhaler _______ minutes apart. Monitor student to check for zone change.	Follow **EMERGENCY PLAN**

EMERGENCY PLAN - when the student exhibits symptoms from the RED ZONE:

- Give _________ puffs of inhaler or 1 nebulized treatment.
- If no improvement, treatment can be repeated ______ times ______ minutes apart.
- **If no improvement after a total of ______treatments call 911 and notify parent.**

☐ The inhaler must be kept in the school clinic. Student is not allowed to carry inhaler with them.

☐ This student has been educated and is knowledgeable about asthma and can properly self-administer the prescribed medication. He/ She has been instructed in the proper handling and carrying of the inhaler and that it must be kept out of the reach of other students at all times. He/ She are aware the inhaler must have a current prescription label indicating that it has been prescribed for them. Please allow him/her to carry the inhaler with them while on school property or at school related events.

___________________________ ___________________________ ____________

Health Care Provider Signature Printed Name Date

Tel #: ________________________ Fax #: __________________________

TO BE COMPLETED BY PARENT

I request that inhaler be administered to my child according to the signed protocol from my Health Care Provider. I hereby give my permission for the school nurse to consult with the prescribing physician regarding the above orders.

Parent's Signature: __________________________ Printed name: _____________________________

Date: ___________ Emergency phone numbers: ____

ALLERGY ACTION PLAN

NORTHLAND CHRISTIAN SCHOOL

Name: ________________________________ **Birthdate:** ________________

Student ID: __________________ **Grade:** _____ **Campus:** __________________

TO BE COMPLETED BY HEALTH CARE PROVIDER

EXTREMELY REACTIVE TO THE FOLLOWING FOODS: ____

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted

EPINEPHRINE (BRAND & DOSE): ____________________________

ANTIHSITAMINE (BRAND & DOSE): ____________________________

OTHER (INHALER IF ASTHMATIC): ____________________________

Any SEVERE SYMPTOMS after suspected or known ingestion:
One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

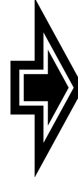
SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring
4. Give additional medications:*
   - -Antihistamine
   - -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort



1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring

☐ The Epinephrine must be kept in the school clinic. Student is not allowed to carry Epinephrine with them.

☐ This student has been educated and is knowledgeable about anaphylaxis and can properly self-administer the prescribed medication. Has been instructed in the proper handling and carrying of the Epinephrine and that it must be kept out of the reach of other students at all times. Is aware the Epinephrine must have a current prescription label indicating that it has been prescribed for them. Should be allowed to have Epinephrine & Antihistamine with them while on school property or at school related events. Student is able to self carry Epinephrine.

__________________________ __________________________ ______________

Health Care Provider Signature **Printed Name** **Date**

TO BE COMPLETED BY PARENT

I request the medication be administered to my child according to the signed protocol from my Health Care Provider. I hereby give my permission for the school nurse to consult with the prescribing physician regarding the above orders.

Parent's Signature: ______________________ Date: ______________________

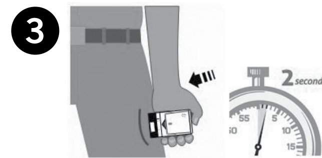
Printed Name: ______________________ Emergency phone numbers: ______________________

EMERGENCY PROCEDURE

Student Name:

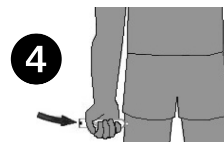
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



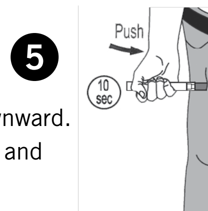
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



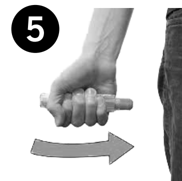
HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

MONITORING INFORMATION: STAY WITH STUDENT. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached.

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ____________________

DOCTOR: ____________________ PHONE: ____________

PARENT/GUARDIAN: ____________________ PHONE: ____________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ____________________ PHONE: ____________

NAME/RELATIONSHIP: ____________________ PHONE: ____________

NAME/RELATIONSHIP: ____________________ PHONE: ____________

Seizure Management and Treatment Plan Form

This form is designed to help create a plan for managing student seizures. It consists of questions about seizure history, medications, precautions, and other considerations. This form should be completed jointly by the student's parents and treating physician and provided to the campus nurse or other appropriately identified personnel.

Student Name: ______________________ **Date of Birth:** ____________ **Date:** ________

Parent/Guardian: ____________________ **Phone:** __________ **Email:** ____________________

Emergency Contact/ Relationship: ____________________ **Phone:** __________ **Email:** ____________________

Seizure Information

Seizure Type	Length (How long it lasts)	Frequency (How often)	What Happens During a Seizure

Known Seizure Triggers or Warning Signs

- ☐ Missed Medicine
- ☐ Emotional Stress
- ☐ Lack of Sleep
- ☐ Physical Stress
- ☐ Flashing Lights
- ☐ Missing Meals
- ☐ Illness with High Fever
- ☐ Alcohol/Drugs
- ☐ Menstrual Cycle
- ☐ Response to specific food or excess caffeine. Specify: ____________________
- ☐ Other: ____________________

VNS/Devices

Devices: VNS ☐ RNS ☐ DBS ☐

Date Implanted: ____________

Magnet Use/Instructions: ____________________

Basic first aid to be provided during a seizure

- **STAY** calm, keep calm, begin timing the seizure
- Keep the student **SAFE**: remove harmful objects, don't restrain, and protect their head
- Turn the student on **SIDE** if not awake, keep airway clear, don't put objects in mouth
- **STAY** until the student recovers
- **SWIPE** magnet for VNS
- Write down what happened during the seizure
- Other: ____________________

When to call 911 – A seizure emergency for the student

- Seizure with a loss of consciousness longer than five minutes and not responding to rescue medicine if available
- Repeated seizures lasting longer than 10 minutes, with no recovery between them and the student is not responding to available rescue medicine
- Difficulty breathing after seizure
- Serious injury occurs or is suspected; seizure in water

When to call student's doctor first

- A change in seizure type, number, or pattern
- Student does not return to usual behavior (i.e., confused for a long period)
- A first time seizure that stops on its own
- Other medical problems or a pregnancy needs to be checked

Student name: ______________________ Date of birth: __________

Seizure Emergency Protocol for District Personnel to Follow

- Administer emergency medications
- Contact school nurse: ______________
- Call 911; transport to ______________
- Notify parent or emergency contact and doctor
- Other: ______________

When and What to Do When Rescue Therapy is Needed

If seizure (cluster, # or length): ______________
Name of Med/Rx: ______________
How much to give (dose): ______________
How to give: ______________

If seizure (cluster, # or length): ______________
Name of Med/Rx: ______________
How much to give (dose): ______________
How to give: ______________

Student's Response and Care After a Seizure

What type of help is needed? ______________
When is the student able to resume usual activity? ______________
Does the student need to leave the classroom? Yes ☐ No ☐
If yes, when can the student return to the classroom? ______________
Is the student able to manage and understand their seizures? Yes ☐ No ☐

Special Instructions

First Responders: ______________
Emergency Department: ______________

Daily Seizure Medication

Medication Name	Dosage	Time to be Given	Common Side Effects	Special Instructions

Other Information

Important medical history: ______________
Allergies: ______________
Epilepsy surgery (type, date, side effects): ______________
Diet therapy: Ketogenic ☐ Low-Glycemic ☐ Modified Atkins ☐ Other: ______________
Special considerations, instructions, or precautions (i.e., school trips, activities, sports, etc.): ______________

Health Care Contacts

Epilepsy Provider: ______________ Phone: ______________
Primary Care: ______________ Phone: ______________
Preferred Hospital: ______________ Phone: ______________
Pharmacy: ______________ Phone: ______________
Parent/Guardian Signature: ______________ Date: ______________
Epilepsy Provider Signature: ______________ Date: ______________