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 t*his 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 Blair Community 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:

IV. MEDICAL MANAGEMENT PLAN

A. Health care services the Student may receive at school relating to Student's Health Condition: See Guidelines (Part V).

B. Evaluation of Student's understanding of and ability to self-manage Student's Health Condition.

The parents/guardians and the Physician certify that the Student has a sufficient level of understanding and ability to self-manage the Student's Health Condition as follows:

1. Access to Prescription Asthma/Anaphylaxis Medication
   - ☐ May have medication in Student's possession at any time.
   - ☐ May have medication in Student's possession when the health office is not accessible (for example, when the Student is out of the school on field trips or participating in extracurricular activities) but should otherwise be maintained in the health office.
   - ☐ May not have medication in Student's possession except for emergency use.

2. Self-Administration of Prescription Asthma/Anaphylaxis Medication
   - ☐ May self-administer independently and without supervision. The Student has had training and is proficient in self-administering medication.
   - ☐ May self-administer when the health office or school staff authorized to administer medication are not readily accessible (for example, when the Student is out of the school on field trips or participating in extracurricular activities); but should otherwise have medication administered by the health office or authorized school staff.
   - ☐ May not self-administer except for emergency use.

C. It is agreed that this Plan permits regular monitoring of Student's self-management of Student's Health Condition by an appropriately credentialed health care professional.

D. Name, purpose and dosage of prescription asthma or anaphylaxis medication prescribed for Student: See Student Asthma/Anaphylaxis Action Plan (Part IV(F)).

E. Procedures for storage and access to backup supplies of such prescription medication for Student's Health Condition:

1. The Student, when permitted to be in possession of medication, will have only the prescription medication that might be needed for the Student's own use. For example, the Student may have one inhaler, but not two, unless the first is nearly empty
2. The school will store any backup supply needed in accordance with its medication storage procedures.
3. The student may have access to the backup supply when necessary by requesting such from the health office.

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	**IF SCHOOL STAFF INVOLVED-- CLOSELY OBSERVE STUDENT AFTER QUICK RELIEF ASTHMA MEDICATION IS ADMINISTERED**
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 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	**IF SCHOOL STAFF INVOLVED--CLOSELY OBSERVE STUDENT AFTER EPINEPHRINE IS ADMINISTERED**
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.	• ***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 or other health care professional who prescribed the medication for treatment of the student's condition. 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: _____

V. GUIDELINES FOR ASTHMA OR ANAPHYLAXIS MEDICAL MANAGEMENT PLAN

Term of Plan: The plan is effective for the current school year. A new plan must be established each school year or more often if changes occur to the student's health or prescribed treatment or student's ability to self-manage.

Medications: The parents or guardians are responsible for supplying any and all prescription asthma/anaphylaxis medications required under the Plan; the school is not responsible for providing the medications. Prescribed asthma/anaphylaxis medications to be used by the Student under this Plan must be furnished in a current original container from the pharmacy with the student's name and the name of the medication, and where applicable, the strength and the dosage to be given. Inhalers must have a label attached to the inhaler itself, not on the packaging. If the prescribed medication, dosage or time of medication changes, the parents or guardians must promptly submit to the school nurse or designee the new prescription and as necessary a new asthma/anaphylaxis action plan. Any non-prescription medication must be furnished in the original container from the manufacturer. The school will store any backup supply needed in accordance with its medication storage procedures. The student may have access to the backup supply when necessary by requesting such from the health office.

Health care services the Student may receive at school relating to Student's Health Condition.

1. Standard health services available to all students.
2. Storage of backup asthma or anaphylaxis medication supplies.
3. Recording of student self-administration reports.

Consultations: The school may consult with a registered nurse or other health care professional employed by such school during development of the plan.

Permitted Self-Management: Pursuant to the Asthma or Anaphylaxis Medical Management Plan the Student shall be permitted to self-manage the Student's asthma or anaphylaxis condition in the classroom or any part of the school or on school grounds, during any school-related activity, or in any private location specified in the plan.

Student Reports of Self-Administration: The Student shall promptly notify the school nurse, the school nurse's designee, or another designated adult at the school when the Student has self-administered prescription asthma or anaphylaxis medication pursuant to the Plan.

Responses to Student Misuse: The possession of medications by Students is a violation of the school's drug and student conduct policies and may result in an expulsion from school. To the extent this Asthma or Anaphylaxis Medical Management Plan permits the Student to be in possession of prescribed asthma/anaphylaxis medications, the Plan allows the Student an exception to the school drug and student conduct policies. However, this exception only extends to the extent provided in the Plan. In the event the Student uses his or her prescription asthma or anaphylaxis medication other than as prescribed, or possesses medication other than as permitted by the Plan, the Student is subject to disciplinary action by the school, up to and including an expulsion. The school will promptly notify the parent or guardian of any disciplinary action imposed. The disciplinary action will not include a limitation or restriction on the student's access to such medication; however, it is agreed that in the event of any such misuse, a re-evaluation of the Student's understanding of and ability to self-manage Student's Health Condition will occur and the re-evaluation may result in a modification or termination of this Plan.

Sharing Plan: It is agreed that this Asthma or Anaphylaxis Medical Management Plan may be shared with school officials and agents who have a need to be aware of it; that those who have the need to be aware of it include student health staff and also include staff responsible for student discipline (e.g. staff need to know that the Student is authorized to have the medication on the 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: _____

Asthma/Allergy Self-Management Log

Student Name_____
Student Date of Birth _____

Date Started	Medication	Dosage	Time	Frequency	Physician	Phone #

Date/time of report	Date/time administration	Observation/Complications	Employee Recording Student Report	Parent Notification
				Date:_____ ☐Phone ☐Form
				Date:_____ ☐Phone ☐Form
				Date:_____ ☐Phone ☐Form
				Date:_____ ☐Phone ☐Form
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Parents/Guardian_____ Phone_____
Teacher_____ Grade_____