Anchorage School District

ASTHMA CARE PLAN

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MM/DD/YYYY)
SCHOOL			GRADE

STUDENT PHOTO

☐ YES ☐ NO **Is this student able to safely carry asthma medication on their person during school hours?**
(If this student is not able to self-treat, a nurse or trained adult may administer the student's asthma medication.)

ASTHMA SEVERITY

☐ **Intermittent**: Symptoms less than or equal to 2 days per week
☐ **Mild**: Symptoms greater than 2 days per week
☐ **Moderate**: Symptoms daily
☐ **Severe**: Symptoms several times per day

ASTHMA TRIGGERS

☐ Smoke ☐ Pets ☐ Mold ☐ Dust mites
☐ Tree/grass/ pollens/weed ☐ Strong odors / perfume ☐ Air pollution ☐ Colds / viruses
☐ Stress, anxiety, laughter or strong emotions ☐ Physical exercise ☐ Exposure to dry or cold air ☐ Other

MEDICAL PROVIDER AUTHORIZATION
(Provider have parent/guardian sign Authorization & Agreement page 2-2)

GREEN ZONE	YELLOW ZONE	RED ZONE
• Breathing is easy and unlabored • No cough or wheeze • Student can participate in usual activities and/or engage in play • Peak Flow: _____ (> 80% of personal best) **Administer rescue inhaler 10 - 15 minutes prior to physical activity, if ordered.**	• Wheeze or cough • Feeling chest tightness • Shortness of breath • Exposure to a known trigger • Peak Flow: _____ (50 to 79% of personal best) **Administer rescue inhaler, as ordered. Contact parent/guardian if student's symptoms do not resolve in 10 - 15 minutes.**	• Labored or rapid breathing • Nasal flaring • Persistent cough • Trouble speaking • Chest retractions **Administer rescue inhaler. CALL 911 if symptoms do not improve. (NURSE ONLY- Refer to standing order for EpiPen administration if symptoms are not alleviated with use of rescue inhaler.)**

MEDICATION	USE	DOSE	ROUTE	NOTES
☐ Albuterol Inhaler	Prior to exercise ☐ **As needed** ☐ **Routinely**	_____ puffs	Inhalation	Green Zone
☐ Albuterol Inhaler	**As needed** for asthma symptoms.	_____ puffs Every 4 hours, as needed. May repeat in 10 - 15 minutes if no improvement from initial treatment.	Inhalation	Yellow or Red Zone
☐ Spacer Needed	☐ Other_____			

MEDICAL PROVIDER WITH PRESCRIPTIVE AUTHORITY IN ALASKA (PRINTED)	TELEPHONE NUMBER 907-562-2944
MEDICAL PROVIDER SIGNATURE AND CREDENTIALS	DATE

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ASTHMA CARE PLAN

PARENT / GUARDIAN AGREEMENT & AUTHORIZATION

I request that the medication(s) selected and asthma protocols listed on this plan be provided to my child. **I will provide needed medications or supplies for care in school.** I understand that, in the absence of the nurse, other trained Anchorage School District ("ASD") personnel may administer this medication.
I agree to defend and hold school district employees harmless from any liability for the results of the care, or the manner in which it is administered. I agree to defend and indemnify the school district and its employees for any liability arising out of these arrangements. I will notify the school immediately if the medication is changed. I give permission for the exchange or release of health information between the medical provider listed above and the school district as part of the provision of my child's care. I agree for the nurse to share health information with school staff on a need-to-know basis for my child's safety and to foster academic success. I understand that this medication(s) will be disposed of at the end of the school year unless I pick up the remaining medication(s) by the last school day, as indicated on the ASD school year calendar.

PARENT / GUARDIAN NAME (PRINTED)	RELATIONSHIP TO CHILD	TELEPHONE NUMBER
PARENT / GUARDIAN (SIGNATURE)		DATE

Prescription medication must be in the original pharmacy container labeled with the following information: student name, medication, dosage, route, administration time, ordering healthcare provider, pharmacy, date issued, and prescription number.

STUDENT SELF-CARRY AGREEMENT

I have been trained in the use of my asthma medication. I understand the signs and symptoms of an asthma reaction and agree to have my asthma medication available at all times. I will notify a responsible adult (teacher, nurse, coach, noon duty, etc.) IMMEDIATELY if my asthma medication does not help with my asthma symptoms. I will not share my medication with other students or leave my medication unattended. I will use my asthma medication only for the prescribed purpose.

STUDENT NAME (PRINTED)	
STUDENT SIGNATURE	DATE

NURSE PLAN REVIEW

I have reviewed the *Asthma Care Plan* for accuracy and ensure that all required fields and signatures are completed before administering medication to a student. I approve of the agreement arranged between the physician, parent, nurse, and student for the management of the student's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the student in the school setting.

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE