Anchorage School District

Asthma Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

STUDENT PHOTO

MEDICAL PROVIDER AUTHORIZATION

ASTHMA TRIGGERS

☐ Smoke ☐ Pets ☐ Mold ☐ Dust mites ☐ Tree/grass/pollen/weeds ☐ Colds/viruses
☐ Strong odor/perfume ☐ Air pollution ☐ Stress/anxiety/laughter/strong emotions
☐ Physical exercise ☐ Exposure to dry or cold air ☐ Other _____

SEVERITY

☐ **Intermittent:** *Symptoms < 3 days/week*
☐ **Mild:** *Symptoms > 2 days/week*
☐ **Moderate:** *Symptoms daily*
☐ **Severe:** *Symptoms several times/day*

RESCUE MEDICATION

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

☐ Albuterol Sulfate 90 mcg _____ puffs

☐ PRN for Yellow or Red Zone symptoms. May repeat in 10-15 minutes.
☐ PRN prior to physical activity.
☐ Routine prior to physical activity.

☐ with spacer
☐ without spacer

☐ Other Medication/Order:

ZONES

Green	Yellow	Red
• 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 immediately if ordered above. 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 immediately as ordered. 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.)*

MEDICAL PROVIDER NAME/TITLE	*PHONE NUMBER*	*EMAIL*
MEDICAL PROVIDER SIGNATURE		*DATE*

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL

Anchorage School District

Asthma Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH

PARENT/GUARDIAN AGREEMENT AND 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.

THIS CARE PLAN EXPIRES AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL

PARENT/GUARDIAN NAME	*RELATIONSHIP TO STUDENT*	*PHONE NUMBER*

PARENT/GUARDIAN SIGNATURE	*DATE*

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	
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 child. I approve of the agreement arranged between the physician, parent, nurse, and child for the management of the child's health needs. I will conduct training with school staff, as needed, to ensure the safety and well-being of the child in the school setting.

NURSE NAME	
NURSE SIGNATURE	*DATE*