Anchorage School District

Asthma Care Plan

Student:	DOB:	Grade:	Student ID:

Hx of Condition

Asthma Triggers:	**Severity:**
Student can self-carry and administer medications: ☐ All ☐ Rescue only ☐ No	

Medical Provider Orders

Symptoms	**Treatment** **Guidelines adopted from AAFA Asthma Action Plan*		
Green Zone	**Give these daily medications**		
Student has *all* of these ▪ Breathing is normal ▪ No cough or wheeze ▪ Can participate in school activities Peak Flow: _____ to _____	Medication & Route	Dose	Frequency
	Prior to exercise or recess, give:		
Yellow Zone	**Give these rescue medications**		
Student has *any* of these ▪ First signs of a cold ▪ Exposure to known trigger ▪ Short of breath ▪ Mild cough or wheeze ▪ Tight chest Peak Flow: _____ to _____	Medication & Route	Dose	Frequency
	▪ *Monitor and give second dose if no improvement within 10-15 minutes and contact parent/guardian.* ▪ *Monitor for 10-15 minutes after second dose and move to Red Zone if symptoms do not improve.*		
Red Zone	**Give these rescue medications and CALL 911**		
Student's asthma is worsening or no response. ▪ Minimal, or no response to yellow zone medications ▪ Labored or rapid breathing ▪ Nasal flaring ▪ Trouble speaking ▪ Chest retractions Peak Flow Below: _____	☐ Albuterol 90 mcg 4 puffs Q15 minutes up to 3 times max. ☐ Other: _____		
Additional Orders/Notes *(activity restrictions, environmental controls, outside temp restrictions, etc.)*			

Medical Provider:	NPI:	Phone:
Signature:	Email:	Date:

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Parent/Guardian Authorization

I request that the medication(s) 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 way 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.

Name:	Phone:
Signature:	Date:

This authorization expires at the end of the current school year.

Student Self-Carry Agreement

It is indicated within the Medical Provider Orders of this Asthma Care Plan that I may self-carry medications. I have been trained in the use of my asthma medication. I understand the signs and symptoms of an asthma reaction and agree to always have my asthma medication available. 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.

Name:	Student ID:
Signature:	Date:

Nurse Delegation for UAP *(initialed and signed by delegating nurse)*

☐ _____ *I **AUTHORIZE** the delegation of the medication(s) and nursing duties within this Care Plan to the "Full UAP" as indicated on the UAP Training Log in accordance with 12 AAC 44.965 and the BON Advisory Opinion NUR_AdOp_Medication. I acknowledge that I have assessed the student and have trained the UAP in utilizing the rescue medications in the event of an emergency. The UAP has been referred to the Drug Facts on the medication packaging for written instructions on storage, administration, dosing, measurement, and timing requirements; expected outcome (Purpose); contraindications (Do Not Use); interactions of medications (Ask a doctor…); unexpected outcomes (Stop use…) and what to do in the event of one; and will contact the nurse (or Healthcare Services when the nurse is unavailable) in the event symptoms worsen or do not improve, or in the event of an unexpected outcome.*

☐ _____ *I **DO NOT AUTHORIZE** the delegation of the medication(s) and nursing duties within this Care Plan.*

Nurse:	Initials:
Signature:	Date: