Optional Student Photo

ASTHMA CARE PLAN *Side 1*

TO BE COMPLETED BY HEALTHCARE PROVIDER

EFFECTIVE DATE:		**END DATE:**
STUDENT'S NAME:	Grade:	Date of Birth:
ASTHMA HEALTHCARE PROVIDER INFORMATION Name/ Clinic:		
Phone #:	Fax #:	
SCHOOL:	Nurse Phone #:	Fax #:

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

☐ **YES** ☐ **NO** **Has this student received instruction in the proper use of his/her 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
☐ Trees / pollen / weeds ☐ Strong odors / perfume ☐ Air pollution ☐ Colds / viruses
☐ Stress, anxiety, 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 _____**hours**, as needed. May repeat in 10 - 15 minutes if no improvement from initial treatment.	Inhalation	Yellow or Red Zone
☐				

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

Optional Student Photo

ASTHMA CARE PLAN *Side 2, Continued:*

TO BE COMPLETED BY PARENT/GUARDIAN AND STUDENT

Student Name:_____ **Birthdate:** _____

List all asthma medications taken each day (including at home).

	Name	*Amount*	*When to Use*
1.			
2.			
3.			

PARENT / GUARDIAN AGREEMENT & AUTHORIZATION

☐ I want this plan implemented and **I authorize (along with consent from the doctor) for my child to carry and self-administer their rescue medication.**

-OR-

☐ I want this plan implemented and **I <u>DO NOT</u> authorize my child to carry and self-administer their rescue medication**. Medications will be stored and administered/supervised by the school nurse.

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 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.** I understand that, in the absence of the nurse, other trained Kodiak Island Borough School District ("KIBSD") 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 KIBSD school year calendar.

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

NURSE PLAN REVIEW

☐ **Approved by School Nurse.** Back up medication is stored at school ☐ Yes ☐ No

Trained Staff Name	***Title***	***Location/Rm #***	***Trained by (RN only)***

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE