Kodiak Island Borough School District

Asthma Care Plan

Optional Student Photo

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

History of Condition

Asthma Triggers:	**Severity:**

Student can self-carry and safely administer medications: ☐ All ☐ Rescue Only ☐ No

(If this student is not able to self-treat, a nurse or trained adult may administer the student's asthma medication.)

Medical Providers 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	Medication & Route	Dose	Frequency
▪ First signs of a cold ▪ Exposure to known trigger ▪ Short of breath ▪ Mild cough or wheeze ▪ Tight chest Peak Flow: _____ to _____			
	▪ *Monitor and give second dose if no improvement within 10-15 minutes and contact the 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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Student:	DOB:	Grade:

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 DO NOT authorize my child to carry and self-administer their rescue medication**. Medications will be stored and administered/supervised by the school nurse.

I authorize the school nurse to train school staff using a standardized curriculum to administer the medication(s) to my child according to this care plan. I understand that, in the absence of the nurse, other trained Kodiak Island Borough School District 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. If I wish to be part of the staff training for my student, I will contact my school nurse to collaborate.

I request that the medication(s) selected and allergy/ anaphylaxis 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 will notify KIBSD immediately if the medications or protocols change. I give permission for the exchange or release of health information between the medical provider listed above and KIBSD as part of the provision of my child's care. I agree for the nurse to share health information with KIBSD staff on a need-to-know basis for my child's safety and to foster academic success. I understand that ANY remaining 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

☐ Reviewed by School Nurse.

☐ *Medication has been received from parent for school use.*

NURSE NAME (PRINTED)	
NURSE SIGNATURE	DATE