



Asthma Care Plan

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
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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. 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 issues, and prescription number.*** I understand that, in the absence of Health Services personnel, other trained Fairbanks North Star Borough School District ("FNSBSD") personnel may administer this medication.

Employees and agents of the Fairbanks North Star Borough School District ("FNSBSD") strive to provide treatment consistent with the appropriate standard of care, but are not infallible. I agree to release, defend, indemnify, and hold harmless 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 Health Services personnel to share health information with FNSBSD school 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 FNSBSD 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, health assistant, 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 student. I approve of the agreement arranged between the healthcare provider, 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 child in the school setting.

NURSE NAME	
NURSE SIGNATURE	DATE

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