



Anchorage School District

Asthma Care Plan



Student:	DOB:	Grade:	Student ID:
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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 <i>all</i> 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 <i>any</i> 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. In the absence of the nurse, I expressly authorize other trained Anchorage School District ("ASD") personnel to 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: