



Fairbanks North Star Borough School District Asthma Action Plan

STUDENT
PHOTO

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SCHOOL		GRADE	STUDENT ID

MEDICAL PROVIDER AUTHORIZATION

ASTHMA TRIGGERS

- ☐ Smoke ☐ Pets ☐ Mold ☐ Dust mites ☐ Tree/grass/pollen/weeds ☐ Colds/viruses
☐ Strong odor/perfume ☐ Air pollution ☐ Stress/anxiety/laughter/strong emotions
☐ Physical exercise ☐ Exposure to dry or cold air ☐ Other _____

SEVERITY CLASSIFICATION

- ☐ **Mild-Intermittent:** Daytime ≤ 2 times/week
☐ **Moderate-Persistent:** Daytime > 2 times per week but < 1 time per day
☐ **Mild-Persistent:** Daytime symptoms daily
☐ **Severe-Persistent:** Daytime symptoms continual, symptoms limit physical activity

RESCUE MEDICATION

Is this student able to safely carry rescue medication on their person during school hours? (If this student is not able to self-treat, a nurse or trained HA/UAP may administer the student's asthma medication.)			☐ YES ☐ NO
☐ Albuterol Sulfate 90 mcg ____ puffs	☐ PRN for Yellow or Red Zone symptoms. May repeat in 10-15 minutes.	☐ with spacer ☐ without spacer	
☐ Symbicort Turbuhaler 80/4.5 mcg ____ puffs	☐ PRN prior to physical activity.		
☐ Symbicort Turbuhaler 160/4.5 mcg ____ puffs	☐ Routine, Daily prior to physical activity.		
☐ Other Medication/Order:			

ZONES

Green	Yellow	Red
- Breathing is easy and unlabored - No cough or wheeze - No chest tightness - Student can participate in usual activities and/or engage in play 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 - Student can do some, but not all usual activities Administer rescue inhaler immediately if ordered above. Contact parent/guardian if student's symptoms do not resolve in 10 - 15 minutes.	Symptoms are getting worse, FAST - Quick-relief medicine is NOT helping - Labored or rapid breathing - Nasal flaring, Chest retractions - Persistent cough - Trouble speaking - Student cannot do usual activities Administer rescue inhaler immediately as ordered. CALL 911 if symptoms do not improve.

MEDICAL PROVIDER NAME/TITLE	PHONE
MEDICAL PROVIDER SIGNATURE	DATE

THESE ORDERS EXPIRE AT THE END OF THE CURRENT SCHOOL YEAR AND MUST BE RENEWED EACH FALL



Fairbanks North Star Borough School District

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 during the school day and during school-sponsored activities, including field trips. 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 issued, 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 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 FNSBSD from any liability for the risks or results of the care, which may include INJURY, ILLNESS, or DEATH, or the manner in which it is administered, including NEGLIGENCE. 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 FNSBSD as part of the provision of my child's care. I agree for Health Services personnel to share health information with FNSBSD employees and agents 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

Complete this section ONLY if student may self-carry his/her medication: 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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