



Fairbanks North Star Borough School District

Fairbanks North Star Borough School District  
520 Fifth Ave. Fairbanks, AK 99701 (907) 452-2000  
www.k12northstar.org

**SCHOOL SUPPLEMENTARY TREATMENT ORDERS**  
(TO BE SENT WITH ASTHMA ACTION PLAN)

Student \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

Rescue Medication \_\_\_\_\_

See attached Asthma Action Plan:

Please follow the treatment plan detailed in the Green zone for activity/exercise treatment and rescue medication plan for Green, Yellow & Red zones, according to asthma symptoms.

Common side effects of albuterol/levalbuterol include increased heart and respiratory rate and jitteriness.

The student may carry and self-administer their inhalers

Pre-activity treatment, including before physical education/recess, should be given:

- With all activity       Only when the child or school staff feels he/she needs it

**If a Student is in the Red Zone, immediately give their rescue treatment and call 911. Please follow school emergency plans, according to school/school system policy.**

Controller Medications:

Only the following controller or steroid medications should be administered in school:

	AM Dose	PM Dose
_____		
_____		

If not listed on the Asthma Action Plan

Triggers:

School specific triggers include \_\_\_\_\_

Asthma Severity:  Intermittent     Mild Persistent     Moderate Persistent     Severe Persistent

He/she has had many or severe asthma attacks/exacerbations

Please Contact the Healthcare Provider listed here with any questions or concerns regarding these orders, or if the student does not have adequate/correct medications in the school.

Healthcare Provider \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Permission: I give permission for the medications listed in the Asthma Action Plan to be administered in the school by the nurse or other school members in accordance with school policy. I consent to sharing health information between the prescribing health care provider/clinic, the school nurse, and the school medical advisor necessary for asthma management and administration of this medication.

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

School Nurse Reviewed \_\_\_\_\_ Date \_\_\_\_\_

School nurse agrees with student self-administering the inhalers