



TWINSBURG CITY SCHOOL DISTRICT

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Denise Traphagen, Director of Pupil Services
Andrea Walker, Director of Student Wellness
Chad C. Welker, Business Manager

LETTER TO PARENTS ASTHMA

TO: Parents
FROM: School Health Clinic
DATE: _____
Subject: Asthma

You have told us that your child has asthma.

Please fill out the ***Asthma Action Plan*** and return it. The Plan will be shared with the appropriate school personnel such as your child’s classroom teacher(s) and physical education teacher. This information will help them work with your child to minimize unnecessary restrictions, feelings of being treated differently, and possible absenteeism.

To help your child, please let us know of changes in your child’s asthma or medication schedule.

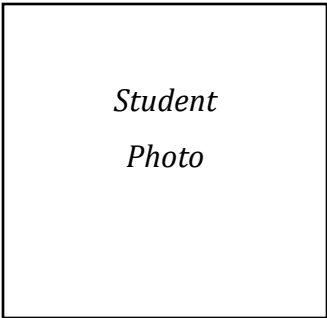
Please use the numbers below to fax back any forms to the appropriate school.

SCHOOL BUILDING	GRADES	FAX NUMBER
Twinsburg High School	9-12	330-405-7406
R.B. Chamberlin Middle School	7-8	330-963-8313
George G. Dodge Intermediate School	4-6	330-963-8323
Samuel Bissell Elementary School	2-3	330-963-8333
Wilcox Primary School	PreK, K-1	330-963-8332

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ASTHMA ACTION PLAN



Student
Photo

Student Information:

Student: _____ Birthdate: _____
School: _____ Grade/Rm. _____

Emergency Contact Information:

Name	Relationship	Telephone number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Healthcare Provider _____ Tel _____

Asthma Emergency Action:

The following are possible signs of an asthma emergency:

- Difficulty breathing, walking, or talking
- Blue or gray discoloration of the lips or fingernails
- Failure of medication to reduce worsening symptoms.

These signs indicate the need for emergency medical care. The steps that should be taken:

- Activate the emergency medical system in your area. Call 911.
- Call Parent/Guardian and/or Healthcare Provider

Triggers: _____

Name of Medication	Dosage	Time

Start Date _____ End Date _____

Steps for an Acute Asthma Episode (to be completed by prescriber)

1. Administer Inhaler as ordered.
2. If no relief in _____ minutes, Repeat Inhaler as ordered.
3. Contact Parent/Emergency Contact
4. Call 911
5. Additional Instructions:

Please check if STUDENT is permitted by healthcare provider to CARRY an inhaler and SELF-MEDICATE at school. (See next page.) (In accordance with ORC 3313.716/3313.14)

Signature of Prescriber _____ Date _____

Signature of Parent/Guardian _____ Date _____

*******SELF-MEDICATION FOR ASTHMA INHALERS*******
(In accordance with ORC 3313.716/3313.14)

Adverse reactions that should be reported to physician:

- Chest pain.
- Rash, hives, or itching.
- Fast, pounding, or irregular heartbeat.
- Swelling of the face, throat, tongue, lips, eyes, hands, feet, ankles, or lower legs.
- Difficulty swallowing.
- Worsened breathing.
- Hoarseness.

Adverse reactions for unauthorized user:

- Racing heart beat
- Feeling very shaky

In the event that medication does not produce the expected relief from student’s asthma attack, follow the “Steps for an Acute Asthma Episode” (on first page)

Other special instructions:

Copies must be provided to the principal and to the nurse.

Reviewed by Dr. Carly Wilbur April 2019

