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.

<table>
<thead>
<tr>
<th>SCHOOL BUILDING</th>
<th>GRADES</th>
<th>FAX NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twinsburg High School</td>
<td>9-12</td>
<td>330-405-7406</td>
</tr>
<tr>
<td>R.B. Chamberlin Middle School</td>
<td>7-8</td>
<td>330-963-8313</td>
</tr>
<tr>
<td>George G. Dodge Intermediate School</td>
<td>4-6</td>
<td>330-963-8323</td>
</tr>
<tr>
<td>Samuel Bissell Elementary School</td>
<td>2-3</td>
<td>330-963-8333</td>
</tr>
<tr>
<td>Wilcox Primary School</td>
<td>PreK, K-1</td>
<td>330-963-8332</td>
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...where the schools and the communities are one...
ASTHMA ACTION PLAN

Student____________________________________
DOB_________________________________
Teacher/Grade_______________________________
Transportation:  ☐ Bus  ☐ Car (Parent/Guardian)

EMERGENCY CONTACTS – Please complete the Emergency Contacts below:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Telephone Number</th>
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Healthcare Provider______________________________ Phone __________

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. Take the following steps:
- Call 9-1-1.
- Call Parent/Guardian or Emergency Contacts and/or Healthcare Provider.

Triggers:

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>Time</th>
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</table>

Steps for an Acute Asthma Episode (to be completed by physician)
1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________
4. ____________________________________________________________

Physician Signature____________________________________ Date________________________
Parent Signature____________________________________ Date________________________

PLEASE COMPLETE THE NEXT PAGE FOR PERMISSION TO CARRY AN INHALER
To be completed ONLY if student will be carrying an Inhaler

AUTHORIZED FOR STUDENT POSSESSION AND USE OF AN INHALER

(In accordance with ORC 3313.716/3313.14)

Student name

Student address

This section must be completed and signed by the student's parent or guardian.

Parent/Guardian signature

Date

Parent/Guardian name

Parent/Guardian emergency telephone number

This section must be completed by the medication prescriber.

Name and dosage of medication

Date medication administration begins

Date medication administration ends

Circumstances for use of the inhaler

Procedures for school employees if the medication does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the prescriber)

To a student for which it is not prescribed who receives a dose

Special instructions

This section must be signed by the medication prescriber. As the prescriber, I have determined that this student is capable of possessing and using this inhaler appropriately and have provided the student with training in the proper use of the inhaler.

Prescriber signature

Date

Prescriber name

Prescriber emergency telephone number

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