TWINSBURG CITY SCHOOL DISTRICT

11136 Ravenna Road • Twinsburg OH 44087-1022
Phone: 330.486.2000
Fax: 330.425.7216

Kathryn M. Powers, Superintendent
Martin Aho, Treasurer
Jennifer Farthing, Director of Curriculum

Belinda McKinney, Director of Human Resources
Denise Traphagen, Director of Pupil Services
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

"... where the schools and the communities are one."

Twinsburg City School District

11136 Ravenna Road
Twinsburg, OH 44087
330.486.2000

❑ Twinsburg High School	330.486.2400	❑ Samuel Bissell Elementary School	330.486.2100
❑ RB Chamberlin Middle School	330.486.2281	❑ Wilcox Primary School	330.486.2030
❑ George G. Dodge Intermediate School	330.486.2200		

ASTHMA ACTION PLAN

Place Student's Picture here

Student_____

DOB_____**School**_____

Teacher/Grade_____

Transportation: ❑ **Bus** ❑ **Car (Parent/Guardian)**

EMERGENCY CONTACTS – Please complete the Emergency Contacts below:

Name *Relationship* *Telephone Number*

1. _____

2. _____

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: _____

Name of Medication	*Dosage*	*Time*

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

Twinsburg City School District

11136 Ravenna Road
Twinsburg, OH 44087
330.486.2000

❑ Twinsburg High School	330.486.2400	❑ Samuel Bissell Elementary School	330.486.2100
❑ RB Chamberlin Middle School	330.486.2281	❑ Wilcox Primary School	330.486.2030
❑ George G. Dodge Intermediate School	330.486.2200		

To be completed ONLY if student will be carrying an Inhaler

AUTHORIZATION 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 ( )