TWINSBURG CITY SCHOOL DISTRICT

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

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

Revised 8/2022

Twinsburg City School District

Student Photo

Student_____DOB_____

School_____Grade/Rm_____

PARENT/GUARDIAN EMERGENCY CONTACT INORMATION:

Parent/Guardian-1 (name/relationship):_____Phone:_____

Parent/Guardian-2 (name/relationship):_____Phone:_____

Asthma Triggers_____ Spacer: _____YES_____NO

Does the student use an Epi-pen: YES / NO

Green Zone: Doing Well

Symptoms: Breathing is good, no cough or wheeze, can play and run

MEDICINE	DOSE	WHEN AND HOW OFTEN TO TAKE IT
FOR ASTHMA WITH EXERCISE, TAKE:		

Yellow Zone: Caution. Child exhibiting some problems breathing

Symptoms: Cough, mild wheeze, tight chest, shortness of breath, problems playing, exposure to known trigger

MEDICINE	DOSE	WHEN AND HOW OFTEN TO TAKE IT

☐ Can repeat dose every 4 hours as needed. If symptoms unresolved or getting worse, follow **red zone**, seek medical attention and contact the parent.

Red Zone: Emergency. Quick-relief medicine has not helped

Symptoms: very short of breath, trouble talking/walking, nasal flaring, use of accessory muscles, blue or gray discoloration of the lips or fingernails. Obtain medical attention right away!

MEDICINE	DOSE
	Number of puffs_____
	Can repeat every_____ minutes up to _____ times

FOLLOW THE YELLOW AND RED ZONE INSTRUCTIONS FOR RESCUE MEDICATION ACCORDING TO THE STUDENT'S SYMPTOMS.

Healthcare Provider: (circle correct response)

YES / NO: Student is PERMITTED to CARRY an inhaler and SELF-MEDICATE at school with the understanding that he/she is to report to the school clinic if symptoms do not improve.

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