



# TWINSBURG CITY SCHOOL DISTRICT

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

**Kathryn M. Powers**  
*Superintendent*

**Julia Rozsnyai**  
*Treasurer*

**Ryan Bandiera**  
*Director of Pupil Services*

**Jennifer C. Farthing**  
*Director of Curriculum*

**Belinda McKinney**  
*Director of Human Resources*

**Matthew Strickland**  
*Business Manager*

**Andrea C. Walker**  
*Director of Student Wellness*

## 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.

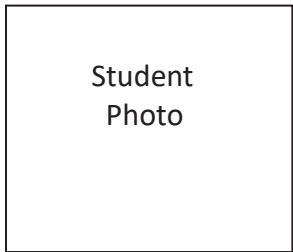
To help your child, please let us know of changes in your child’s asthma or medication schedule.

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

<b>SCHOOL BUILDING</b>	<b>GRADES</b>	<b>FAX NUMBER</b>
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





Student \_\_\_\_\_ DOB \_\_\_\_\_

School \_\_\_\_\_ Grade/Rm \_\_\_\_\_

**PARENT/GUARDIAN EMERGENCY CONTACT INFORMATION:**

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*

