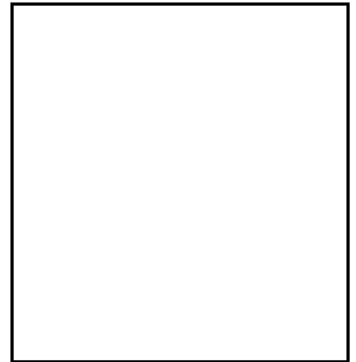
FAIRVIEW PARK
CITY SCHOOLS

ADMINISTRATIVE OFFICES
21620 Mastick Road, Fairview Park, OH 44126 • P: (440) 331-5500 • F: (440) 356-3545

Asthma Action Plan



Student Information:

Student Name: ____ Birthdate: ____________________

School: ____ Grade/Rm: _________________

Emergency Information:

Parent(s) or Guardian(s):

Mother: Cell:___________________________________ Tel (H): ______________________________

Father: Cell:___________________________________ Tel (H): ______________________________

Healthcare Provider __________________________________ Tel: _____________________________

In case of emergency, contact:

1. Name ____ Tel: ____________________________
2. Name ____ 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

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Triggers: ____

Name of Medication	Dosage	Time

Start Date: ____________________________________End Date: ____________________________________

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

1. ____

2. ____

3. ____

4. ____

Signature of Parent/Guardian: ____ **Date:** _________________

Signature of Prescriber: ____**Date:** _________________

PLEASE COMPLETE NEXT PAGE FOR PERMISSION TO CARRY INHALER

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************Self-Medication for Asthma Inhalers*************

Authorization

(In accordance with ORC 3313.716/3313.14)

________ Check if STUDENT is permitted by healthcare provider to CARRY an inhaler and SELF- MEDICATE at school.

Complete the following and parent/guardian and healthcare provider must SIGN below:

Student Name: ____

Medication: ____

Dosage/Time(frequency): ____

Date to Begin Administration: _______________________ Date to End Administration: ______________________

Adverse reactions that should be reported to physician: ____

Adverse reactions for unauthorized user: ____

Procedure to follow in the event that medication does not produce the expected relief from student's asthma attack:

____

____

Other special instructions: ____

Prescriber and Parent/Guardian Names and Signatures REQUIRED for Self-Medication of Asthma Inhalers:

Prescriber Name: ______________________________________ Tel: ____________________________

Signature of Prescriber: _________________________________ Date: ___________________________

Parent/Guardian Name(s): _____________________________ Tel: ____________________________

Signature of Parent/Guardian: __________________________ Date: ___________________________