



FAIRVIEW PARK CITY SCHOOLS

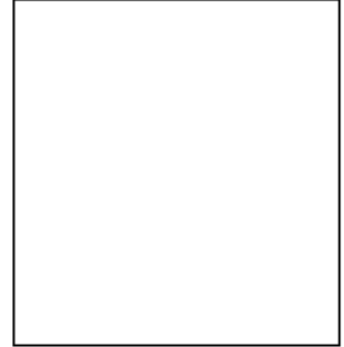
ADMINISTRATIVE OFFICES

21620 Mastick Road • Fairview Park, OH 44126 • P: (440) 331-5500 • F: (440) 356-3545
Dr. William W. Wagner, Superintendent • Kimberly Sperling, Treasurer

BOARD OF EDUCATION

Joseph Shucofsky, President
Kellie DuBay Gillis, Vice President
Joslyn Dalton, Board Member
Matthew Hrubey, Board Member
Mark St. John, Board Member

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: _____