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

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: _____