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 attached ***Asthma Action Plan*** and return it. I will share the information with the appropriate 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.

Enclosure

Proprietary information of PSI Affiliates, Inc. May not be copied without consent.

ASTHMA ACTION PLAN

Student Photo

Student Information:

Student: ______________________ Birthdate: ______________

School: ______________________ Grade/Rm. ______________

Emergency Information:

Parent(s) or Guardian(s) ______________________

Mother: Tel (W) ______________ Tel (H) ______________

Father: Tel (W) ______________ 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

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

************SELF-MEDICATION FOR ASTHMA INHALERS************* Authorization

(In accordance with ORC 3313.716/3313.14)

❑ **Please 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 _______________________

Copies must be provided to the principal and to the nurse.