From the Desk of the School Nurse

Dear Parents

According to our health records, your child has a history of asthma. Would you please fill out the attached "Asthma Action Plan" and return it to school so that we can provide appropriate care to your child.

If you would like **school personnel to assist** your child with medication or you wish for medication to be stored in the clinic during the school year, the **"Request to Administer Prescribed Medication"** form needs to be completed by the doctor and signed by you.

If you would like your **child to carry an inhaler** during school hours, **the "Authorization for Student Possession"** form needs to be completed by the doctor and signed by you. Your child will then be responsible for the safe storage, appropriate usage, and reporting the use to a parent.

Please call if you have questions.

Sincerely,

School Nurse

*For other information from Health Services (including nurses' schedules, area clinics, medications forms, and more), go to the district web site at www.wcsoh.org , select "Departments" from the header bar, then Department of Community Relations and click on Health Services

Asthma Action Plan

AMERICAN LUNG ASSOCIATION®

General Information:

■ Name _____

■ Emergency contact _____ Phone numbers _____

■ Physician/healthcare provider _____ Phone numbers _____

■ Physician signature _____ Date _____

Severity Classification

❍ Intermittent ❍ Moderate Persistent
❍ Mild Persistent ❍ Severe Persistent

Triggers

❍ Colds ❍ Smoke ❍ Weather
❍ Exercise ❍ Dust ❍ Air Pollution
❍ Animals ❍ Food
❍ Other _____

Exercise

1. Premedication (how much and when) _____
_____
2. Exercise modifications _____
_____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- ■ Breathing is good
- ■ No cough or wheeze
- ■ Can work and play
- ■ Sleeps well at night

Control Medications:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- ■ Some problems breathing
- ■ Cough, wheeze, or chest tight
- ■ Problems working or playing
- ■ Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Between 50% and 80% of personal best or
_____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- ❍ Take quick-relief medication every 4 hours for 1 to 2 days.
- ❍ Change your long-term control medicine by _____
- ❍ Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- ❍ Take quick-relief treatment again.
- ❍ Change your long-term control medicine by _____
- ❍ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- ■ Lots of problems breathing
- ■ Cannot work or play
- ■ Getting worse instead of better
- ■ Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Less than 50% of personal best or
_____ to _____

Go to the hospital or call for an ambulance if:

- ❍ Still in the red zone after 15 minutes.
- ❍ You have not been able to reach your physician/healthcare provider for help.
- ❍ _____

Call an ambulance immediately if the following danger signs are present:

- ❍ Trouble walking/talking due to shortness of breath.
- ❍ Lips or fingernails are blue.

WESTERVILLE CITY SCHOOLS

REQUEST TO ADMINISTER PRESCRIBED MEDICATION TO A STUDENT DURING SCHOOL HOURS

As Required By Section 3313.713 Ohio Revised Code

Student Name: Date of Birth:

Student Address:

School: Grade: Teacher:

PARENT SECTION

1. This form must be completed by both the parent (top section) and the prescriber (bottom section)
2. Medication must be kept in the **student's prescription labeled bottle**. (Pharmacy may provide an extra bottle for long-term medication.) Prescription label must match instructions from prescriber. If it is a non-prescription drug, it must be in the original container.
3. Deliver no more than 2 -4 weeks supply of medication to school clinic staff directly by the parent/guardian or other responsible individual at parental request. This should be arranged in advance.
4. A revised statement signed by the prescriber must be provided for any changes. A new form is required every school year.

When possible, give medication outside of school hours. *CONSENT : I, give consent for School Staff to make direct contact with the prescriber should an emergency adverse reaction indicated below occur. This consent does not supersede nor abrogate the "Emergency Medical Form".

Signature of parent: _____ Date: _____

Parental signature authorizes school personnel to administer the below prescribed medication.

Parent phone number: _____ _____

Day time Evening

PHYSICIAN SECTION

I verify that this medication must be taken by: _____

Name of Student

FOR DAILY MEDICATIONS (When possible, please attempt to schedule medication outside of school hours)

DRUG	DOSE	ROUTE	TIME TO BE GIVEN

FOR AS NEEDED MEDICATION

DRUG	DOSE	ROUTE	TIME INTERVAL BETWEEN DOSES

Diagnosis for which medication is prescribed?	
Any severe adverse reactions that should be reported to the prescriber *?	
Special instructions for administration, including sterile conditions and storage?	
Start date to administer at school:	Expiration date:

X

Prescriber's Signature **Date**

Prescriber's Printed Name: Phone:

Prescriber's Address:

If faxed to school, it is the parent's responsibility to ensure it is received **FAX NUMBER:** _____

Ohio Department of Health

Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716/3313.14

A completed form must be provided to the school principal and/or nurse before the student may possess and use an asthma inhaler in school to alleviate asthmatic symptoms, or before exercise to prevent the onset of asthmatic symptoms.

Student name
Student address

This section must be completed and signed by the student's parent or guardian.

As the Parent/Guardian of this student, I authorize my child to possess and use an asthma inhaler, as prescribed, at the school and any activity, event, or program sponsored by or in which the student's school is a participant.

Parent /Guardian signature	Date
Parent/Guardian name	Parent/Guardian emergency telephone number ( )

This section must be completed and signed by the student's physician.

Name and dosage of medication	
Date medication administration begins	Date medication administration ends (if known)

Procedures for school employees if the medication does not produce the expected relief

Possible severe adverse reactions:

To the student for which it is prescribed (that should be reported to the physician)
To a student for which it is ***not*** prescribed who receives a dose

Special instructions

Physician signature	Date
Physician name	Physician emergency telephone number ( )

Adapted from the Ohio Association of School Nurses