Jackson Local Schools
ASTHMA ACTION PLAN

Student's Name: ______________________________ DOB: ______________

Grade: ________ Teacher: ______________________ School Year: ______________

- Does your child have asthma medications at school? ☐ Yes ☐ No
- Where is the medication stored? ☐ Clinic ☐ Student has authorization to carry
- Has your child been trained on the proper use of his/her inhaler? ☐ Yes ☐ No
- Does your child need assistance taking his/her medication? ☐ Yes ☐ No

♦TYPICAL SIGNS OF ASTHMA FOR THIS CHILD♦

☐ Wheezing
☐ Difficulty speaking
☐ Tightness in chest
☐ Coughing
☐ Difficulty breathing
☐ Other: ______________________

♦TRIGGERS OF AN ASTHMATIC EPISODE FOR THIS CHILD♦

☐ Exercise
☐ Dust
☐ Respiratory Infections
☐ Pollen
☐ Temperature changes
☐ Other: ______________________

♦MEDICATION♦

(to be completed by the treating physician)

Medication	Dosage	Frequency
□ Albuterol (ProAir, Ventolin, Proventil) □ Levalbuterol (Xopenex) □ Other:	□ 2 puffs □ 4 puffs □ 1 nebulizer treatment	□ As needed every 4 to 6 hours □ Other:

♦TREATMENT FOR ASTHMATIC EPISODE♦

- Have student sit down and try to remain calm. DO NOT have the student lie down.
- Try giving student sips of warm water.
- Give medications as directed above.
- Observe student for changes in condition.
- Allow student to return to class if symptoms end after using medication

♦ASTHMA EMERGENCY PLAN♦

(to be completed by the treating physician)

☐ If no improvement of symptoms within ________ minutes of using medication listed above, repeat dose. Contact parents and/or school nurse.

☐ **CALL 911 if: (check all that apply)**
- □ No improvement in symptoms after second dose of medication
- □ No improvement in symptoms and unable to reach parent
- □ Chest and/or neck pulling or retracting with breathing
- □ Struggling or gasping while trying to breathe
- □ Lips or fingernails turn grey or blue
- □ Other: ____

I give permission to the school nurse and other designated staff members of Jackson Local Schools to perform the health management tasks as outlined by this Individualized Health Plan. I also consent to the release of the information contained in this plan to all staff members who have custodial care of my child and may need to know this information to maintain my child's health and safety while at school and extracurricular activities.

Parent/Guardian Signature: ______________________________ Date: ______________

Physician Signature/Phone: ______________________________ Date: ______________

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