Insert Student Photo Here

Springboro Community City Schools Health Services

Asthma Action Plan

A completed form must be provided annually to the school health clinic 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 Information

Name

_____D.O.B.____/_____/_____

School/Grade_____/_____ BUS# _____

Asthma Triggers:

_____

Asthma is an emergency if you have:

- Trouble Breathing
- Been struggling to take a breath and are hunched over.
- Your chest and neck muscles pull in with a breath.
- Trouble walking or talking.
- Asthma symptoms that do not go away 15-20 minutes after using a rescue inhaler.
- To stop activity to rest.
- Blue or gray lips or nails ***call 911***

To Be Completed by Physician O SELF-CARRY O CLINIC

Do you consider the student's asthma condition to be life threatening? Yes No

What medications are given **daily?** _____

Is this student approved by physician to **SELF Carry** his/her own inhaler? Yes No

Medications for Quick Relief/School Use:

Medication Name/Dosage: _____

How much to take: _____ puffs _____. May repeat after _____minutes if no improvement noted.

Physical Activity: Is use of the inhaler needed prior to activity/gym: Yes No

Spacer Used: Yes No

Special Instructions: _____

Date for Medication to *Begin*: _____*End:* _____

Physician's Signature _____Date_____

Physician's Name_____ Phone #_____

Completed by Clinic Staff/Medication Check-In/Processing:

Medication/Dosage: _____ Medication Expiration Date: _____

DASL Entry: _____ Health Concern List: _____ EAP Copies Made/Distributed: _____/_____

Medication Sign Out: _____/_____ Date: _____

To be Completed by the Parent:

I have read and understand Springboro Community City Schools Medication Policy. I give my permission for information to be sent to the school district via facsimile.

I, hereby, authorize designated personnel of the Springboro Community City School District to administer the above named medication or procedure as instructed by the physician, and agree to:

1. Provide the school with the medication in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
2. Notify the school if we change physicians.
3. Notify the school if the medication, dosage, or procedures is changed or is to be eliminated.
4. Release authorized school employees from all liability, cause of action, or any other responsibility for administering said medicines as noted above.

Parent/Guardian Signature: _____Date: _____

Phone #1_____#2_____

School Staff Signature:_____Date:_____

Form Revision SCCS 5/2024

School Activity Participation (*Grades 7-12)

Band JROTC Athletics_____