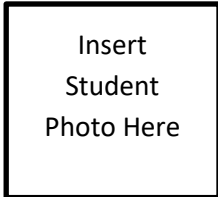


Springboro Community City Schools Health Services
Asthma Action Plan



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.

<p>Student Information</p> <p>Name _____ D.O.B. ____/____/____</p> <p>School/Grade ____/____ BUS# _____</p> <p>Asthma Triggers: _____</p>	<p>Asthma is an emergency if you have:</p> <ul style="list-style-type: none"> • 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

SELF-CARRY 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:** _____