FORT THOMAS INDEPENDENT SCHOOLS
ASTHMA ACTION PLAN

Name:_____Grade:_____Age:_____

Daily Asthma Management Plan
Identify the things which start an asthma episode *(check each that applies to the student)*

- ❑ Exercise
- ❑ Respiratory infections
- ❑ Change in temperature
- ❑ Food:_____
- ❑ Strong Odors or fumes
- ❑ Pollens/Molds
- ❑ Animals
- ❑ Other:_____

Signs and Symptoms student will likely exhibit (Check all that apply)
***Note: Parent/Guardian will be contacted if symptoms persist**
____Coughing ____Wheezing ____ Labored/Difficulty Breathing
Other (Specify): _____

Recommended Preventative/Interventive Measures (Check all that apply)
____Encourage student to assume position of comfort
____Offer warm liquid to drink
____Encourage slow, even breaths

This student has been trained to use his/her inhaler and should be allowed to carry and use their prescribed inhaler on his/her own.
____Yes* ____ No
***It yes, please note: Student will be expected to carry and use his/her inhaler responsibly.**

Steps for an Acute Asthma Episode
(to be completed by physician)
1._____
2._____
3._____

Asthma Emergency Action
These signs indicate the need for emergency medical care:

- **difficulty breathing, walking, or talking**
- **blue or gray discoloration of the lips or fingernails**
- **failure of medication to reduce worsening symptoms**
- **stops playing and can't start activity again**

. The steps that should be taken are:

- **activate the emergency medical system (911)**
- **call parent/guardian or physician**

Parent's/guardian
signature:_____Date:_____

Physician's
signature:_____Date:_____

Administration of Medication Form

FORT THOMAS INDEPENDENT SCHOOL DISTRICT

Robert D. Johnson Elementary
441-2444 fax: 572-4948

Ruth Moyer Elementary
441-1180 fax: 441-9440

Samuel Woodfill Elementary
441-0506 fax: 441-2755

Highlands Middle School
441-5222 fax: 441-4210

Highlands High School
781-5900 fax: 442-4212

Dear Parent or Guardian:

If your child requires medication, if possible, please try to schedule it before or after school hours. If the medication is to be given during school hours, we must have this form completed and signed by you and your child's physician. Your doctor may fax this form to the school office. The duration of this form is for one (1) school year only.

SCHOOL YEAR_____

Name:_____ Date of Birth_____

Grade:_____ Allergies:_____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZED PROVIDER

Medication:_____ Dosage:_____ Directions:_____

Administration Time: Lunch____or_____ Route:_____ Diagnosis:_____

Possible side effects: _____ Duration: Start:_____ Stop:_____

Medication:_____ Dosage:_____ Directions:_____

Administration Time: Lunch____or_____ Route:_____ Diagnosis:_____

Possible side effects: _____ Duration: Start:_____ Stop:_____

Medication:_____ Dosage:_____ Directions:_____

Administration Time: Lunch____or_____ Route:_____ Diagnosis:_____

Possible side effects: _____ Duration: Start:_____ Stop:_____

****For inhaler, Epipen, FDA approved seizure rescue medication, and/or Glucagon, the student has received training to carry the inhaler or emergency medication and may carry and self-administer this medication. ☐ YES ☐ NO

****For field trips, the student has received training and may carry and self-administer the medication/s listed above. ☐ YES ☐ NO

I give permission for the administration of this medication/s by trained school personnel according to standard school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication/s. School officials may need to contact the ordering physician if additional information is needed. I hereby authorize release of any needed information from the ordering physician regarding this medication. Student may self-administer the above medication/s with school trained personnel supervision while on a field trip. In the case of field trips or school related functions, slight adaptations to the time the medication is administered may also be necessary.

Parent/Guardian Signature	Parent's Phone	Date
Physician's Signature	Physician's Phone	Date
Print Physician's Name	Physician's Address	Fax Number

For student health services/procedures not involving medication only, please refer to 09.22 AP.22.

REVIEW/REVISED:7/11/2016

FORT THOMAS INDEPENDENT SCHOOLS
EMERGENCY MEDICATION ADMINISTRATION
DURING EXTRACURRICULAR ACTIVITIES

Student Name: _____
Grade: _____
Date: _____

Please list any sports/extracurricular activities that your child will be participating in during the school
year: _____

I, _____, parent of _____,
am aware that my child may require the administration of _____ in an emergency situation that occurs before or after normal school hours. I agree to inform the school nurse that my child will participate in extracurricular activities and to inform the coach, leader or responsible adult for these extracurricular activities of my child's condition. **I will supply additional necessary emergency medications or supplies to coaches/leaders for use during these activities.** The school nurse will make available the necessary training to coaches/leader in the administration of these medications. If emergency medication administration is required, 911 will also be called.

If I do not make the medications available, I understand and agree that only 911 will be called in the event of an emergency.

If my child adds additional activities during the school year, I agree to notify the school nurse and coaches/leaders or responsible adult for these extracurricular activities of my child's condition.

_____ _____
(Signature of parent/guardian) *(Date)*