Aurora City Schools

www.aurora-schools.org

Board of Education
102 E. Garfield Rd.
Aurora, OH 44202
330-562-6106
Fax: 330-562-4892

Miller Elementary
646 S. Chillicothe Rd.
Aurora, OH 44202
330-562-6199
Fax: 330-995-5459

Craddock Elementary
105 Hurd Rd.
Aurora OH 44202
330-562-3175
Fax: 330-954-2087

Leighton Elementary
121 Aurora-Hudson Rd.
Aurora OH 44202
330-562-2209
Fax: 330-562-2265

Harmon Middle School
130 Aurora-Hudson Rd.
Aurora OH 44202
330-562-3375
Fax: 330-562-4796

Aurora High School
109 W. Pioneer Trail
Aurora OH 44202
330-562-3501
Fax: 330-562-3588

Asthma

Dear Parent/Guardian

You have told us that your child has asthma. In preparation for the upcoming school year, the following forms must be completed.

1. Asthma Action Plan: completed each school year and signed by Physician and Parent

2. If your student is permitted to self carry and self administer his/her inhaler, please be sure that both pages of the Action Plan are completed and signed by Parent/Guardian and Physician.

All medications must be in their original containers, clearly labeled with a date that is within the current school year. Medication MAY NOT be sent to school with the student (unless they self carry). Parent/Guardian to deliver medication to school.

If you choose not to have medication available at school, please notify the nurse in your child's building.

Please call your child's designated school clinic if you have questions, we would be happy to help you.

Aurora City School District
Asthma Action Plan

Student name	Date of birth	Effective dates / / to / /
Health Care Provider		**Provider's Phone**
Parent/Guardian	**Parent/Guardian phone**	**Student Grade**
Emergency Contact	**Contact Phone**	**Additional contact**
Asthma Severity ☐ **Intermittent** **or** **Persistent:** ☐ Mild ☐ Moderate ☐ Severe	**Asthma triggers (Things that make your asthma worse)** ☐ Colds ☐ Smoke (tobacco, incense) ☐ Pollen ☐ Dust ☐ Animals:__________ ☐ Strong odors ☐ Mold/moisture ☐ Pests (rodents, cockroaches) ☐ Stress/Emotions ☐ Exercise ☐ Gastroesophageal reflux ☐ Season (circle): Fall, Winter, Spring, Summer	**GREEN means Go!** Use CONTROL medicine daily **YELLOW means Caution!** Add RESCUE medicine **RED means DANGER!** Get help from a doctor now!

Green Zone: Go! — Take these CONTROL (PREVENTION) medicines EVERY Day

You have **ALL** of these:
- Breathing
- No cough or wheeze
- Can work and play
- Can sleep all night

☐ No control medicines required.
☐ ______________________________, _______ puff(s) **MDI with spacer** __ times a day
☐ ______________________________, _______ nebulizer treatment (s) ___ times a day
☐ ____________________________, take _______by mouth ______daily at _________

For asthma with exercise, ADD
☐______________________, _________puffs _______minutes before exercise

Other Special Instructions:

Yellow Zone: Caution! — Continue CONTROL Medicines and ADD RESCUE Medicines

You have **ANY** of these:
- Cough or mild wheeze
- Tight chest
- Problems sleeping, Working, or playing

☐ _______________________, _______ puff with spacer every_____ hours as needed
☐ _______________________, _______ nebulizer treatment (s) every ______hours as needed
☐ Other ____

Other Special Instructions:

Red Zone: DANGER! — Take these Medicines AND CALL 911!

You have **ANY** of these:
- Can't talk, eat, or walk well
- Medicine is not helping
- Breathing hard and fast
- Blue lips and fingernails
- Tired or lethargic
- Ribs show
- Flared nostrils
- Shortness of breath

☐ _______________________, _______ puffs **every _____ minutes**, for _____ treatments
☐ _______________________, _______ nebulizer treatment (s) every ______hours as needed
☐ Other ____

Other Special Instructions:

CALL 911!

School Medicine Consent and Health Care Provider Order

Check all that apply:

☐ **Permission to self carry and administer inhaled medication: Please check here if STUDENT is permitted by Healthcare Provider to self carry and self administer their inhaler at school. (In accordance with ORC** 3313.716).
☐ **IF CHILD IS AUTHORIZED TO CARRY/ADMINISTER INHALER, page 2 MUST be completed**
☐ **Student needs supervision or assistance to use his/her inhaler.**
☐ **Student should NOT carry his/her inhaler while at school**

Prescriber Signature:______________________________________ **Date:**____________________

Other REQUIRED Signatures

I give permission for the school personnel to follow this plan, administer medication and care for my child and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Management Plan for my child

Parent signature______________________________________ **Date:**____________________

Authorization for Student Possession and Use of an Asthma Inhaler

In accordance with ORC 3313.716

A completed form MUST be provided 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 name
Student address

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

Possible severe adverse reactions:

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

Special instructions	
Physician Signature	**Date**
Physician name	Phone number

This section must be completed and signed by the student's parents 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 phone number

Student information

Student name	
☐ I plan to keep my inhaler with me at school as my doctor or health provider ordered. ☐ I agree to use my inhaler in a responsible manner as ordered ☐ I will notify the school clinic if my inhaler has been used ☐ I will never allow any other person to use my inhaler ☐ I will demonstrate how to properly administer inhaler to the school nurse	
Student signature:	Date: