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

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Student Asthma Action Card

National Asthma Education and Prevention Program

Name:______________________ Grade: __________ Age:______

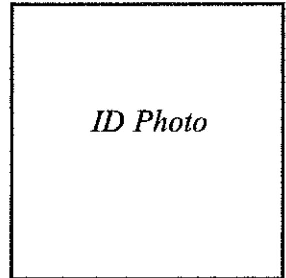
Homeroom Teacher:______________________ Room: __________

Parent/Guardian Name: ______________________ Ph: (h): __________

Address: ______________________ Ph: (w): __________

Parent/Guardian Name: ______________________ Ph: (h): __________

Address: ______________________ Ph: (w): __________



Emergency Phone Contact #1 ______________________________________
Name Relationship Phone

Emergency Phone Contact #2 ______________________________________
Name Relationship Phone

Physician Treating Student for Asthma: ______________________ Ph: __________

Other Physician:______________________ Ph: __________

Emergency Plan

Emergency action is necessary when the student has symptoms such as, __________ , __________, __________ , __________or has a peak flow reading of __________.

• Steps to take during an asthma episode:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if ______________________________________
4. Re-check peak flow.
5. Seek emergency medical care if the student has any of the following:
   - ✔ Coughs constantly
   - ✔ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
   - ✔ Peak flow of __________
   - ✔ Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Stooped body posture
     - Struggling or gasping
   - ✔ Trouble walking or talking
   - ✔ Stops playing and can't start activity again
   - ✔ Lips or fingernails are grey or blue

If This Happens, Get Emergency Help Now!

• Emergency Asthma Medications

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

See reverse for more instructions

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
☐ Animals
☐ Food ____________________
☐ Strong odors or fumes
☐ Chalk dust / dust
☐ Carpets in the room
☐ Pollens
☐ Molds
☐ Other ____________________

Comments ____________________

- **Control of School Environment**

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.) ____________________

- **Peak Flow Monitoring**

Personal Best Peak Flow number: ____________________

Monitoring Times: __________ __________ __________ __________

- **Daily Medication Plan**

	Name	Amount	When to Use
1.			
2.			
3.			
4.			

Comments / Special Instructions

____

For Inhaled Medications

☐ I have instructed ____________________ in the proper way to use his/her medications. It is my professional opinion that ____________________ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that ____________ should not carry his/her inhaled medication by him/herself.

____________________ Physician Signature ____________ Date

____________________ Parent/Guardian Signature ____________ Date