UNIONTOWN AREA SCHOOL DISTRICT

205 Wilson Avenue
Uniontown, PA 15401

Telephone: 724-438-4501
FAX: 724-437-7007

District Website: www.uasdraiders.org

Deborah Rittenhouse
Curriculum Coordinator K-12
Ext. 1604

Jill S. Regan
Business Manager
Ext. 1644

Sally E. Matthews
Asst. Business Mgr./Federal Programs
Ext. 1643

Dr. Charles D. Machesky
Superintendent
Ext. 1606

Judith J. Means
Board Secretary
Ext. 1606

Daniel Bosnic
Asst. to Superintendent
Ext. 1606

Dr. Annette M. Conti
Supervisor of Special Education
Ext. 1609

Robert D. Smalley
Director of Buildings and Grounds
Ext. 1652

Bill Collier
Asst. Director of Bldgs/Grounds
Ext. 1652

HF30

Dear Parent/Guardian:

You have told school personnel that your child has asthma. Please complete the attached school asthma record and return it to me. I will share the information with the appropriate personnel such as your child's classroom teacher(s) and physical education teacher. This will help them work with your child to decrease unnecessary restrictions, feeling of being treated differently, and possible absenteeism.

In addition, please let me know of any changes in your child's asthma or medication schedules.

Sincerely,

School Nurse

ljm

Uniontown Area School District
205 Wilson Avenue
Uniontown, PA 15401

School Asthma Plan

School Asthma Plan (completed by parent)

Name:_____ **Grade:**_____ **Age:**_____

Teacher:_____

Parent/Guardian Name:_____ **Phone(H):**_____

Address:_____ **Phone(W):**_____

Emergency Phone Contact #1:_____ **Phone:**_____
(Name)

Emergency Phone Contact #2:_____ **Phone:**_____
(Name)

Identify the things which start an asthma episode. Check all that apply:

- ☐ **Exercise**
- ☐ **Respiratory Infection**
- ☐ **Change in temperature**
- ☐ **Animals**
- ☐ **Molds**
- ☐ **Strong odors or fumes**
- ☐ **Chalk dust**
- ☐ **Carpets in the room**
- ☐ **Pollen**
- ☐ **Food**
- ☐ **Other**_____

Comments_____

Briefly describe your child's symptoms when having an asthma attack:

I authorize the UASD to distribute medication to my child as ordered by the Physician. I release, discharge, and hold harmless the UASD, its agents and employees from any and all liability in connection with the administration of the medication.

_____ _____
(Signature) **(Date)**

OVER

Student Name:_____

School Asthma Plan (completed by physician)

Asthma Medication

Name	Frequency	Dosage
1.		
2.		
3.		
4.		

In case of an emergency, follow the procedure outline below:

_____

_____

_____

- ☐ **I have instructed (name)_____ in the proper way to use his/her medication. It is my professional opinion that she/he should be allowed to carry and use that medication by herself/himself.**

- ☐ **It is my professional opinion that (name)_____ should NOT carry her/his inhaled medication.**

_____ _____

Physician Signature **Date**