

WCASD - ASTHMA ASSESSMENT

Dear Parent/Guardian:

You have told us that your child has asthma. Please complete this form, including Health Care Provider's signature, and return to the school nurse. This information will be shared with appropriate school staff to help minimize/manage an asthma attack at school.

To help your child, please let the school nurse know of changes in your child's asthma or medication schedules.

CHILD'S NAME _____ GRADE ___ HR ___ HEALTH CARE PROVIDER _____ PHONE _____ PARENT/GUARDIAN _____ HOME PHONE# _____ BUS.PHONE# _____ CELL PHONE _____ BEEPER _____

1. Briefly describe what triggers your child's asthma symptoms:

2. Does your child require treatment before exercise? ____ Yes ____ No

3. Does exercise trigger asthma symptoms? Circle all that apply!!

Cough Wheeze Shortness of Breath Chest Tightness Chest Pain

4. Do certain weather conditions affect your child's asthma?

(List) _____

5. Do you have an asthma management plan? If yes, please give copy to your school nurse!

Table with 4 columns: DAILY MEDICATION PLAN, NAME RX, AMOUNT, WHEN TO USE. Includes blank rows for entry.

EXERCISE PRE-TREATMENT: _____ 15 MINS BEFORE: ____ GYM ____ RECESS

PEAK FLOW MONITORING: PERSONAL BEST PEAK FLOW # _____ MONITORING TIMES: _____

6. Does your child suffer side effects from these medications? _____

7. Does your child understand asthma and what he/she should do to manage his/her asthma? _____

8. How do you want the school nurse to treat an episode of asthma if it should occur? _____

SEEK EMERGENCY MEDICAL CARE IF STUDENT HAS ANY OF THE FOLLOWING (PLEASE CHECK WHERE APPROPRIATE)

- NO IMPROVEMENT 15-20 MINS AFTER INITIAL SYMPTOMS WITH MEDICATION, RELATIVE CAN'T BE REACHED.
PEAK FLOW OF _____
HARD TIME BREATHING WITH:
* CHEST/NECK PULLED IN WITH BREATHING * CHILD HUNCHED OVER * CHILD IS STRUGGLING TO BREATHE
TROUBLE WALKING/TALKING
STOPS PLAYING AND CAN'T START ACTIVITY AGAIN
LIPS/FINGERNAILS ARE GRAY/BLUE

EMERGENCY ASTHMA MEDICATIONS:

Table with 4 columns: NAME OF MEDICATION, DOSAGE, ROUTE ADMIN., WHEN TO USE. Includes numbered rows 1 and 2.

9. HOW OFTEN DOES YOUR CHILD HAVE AN ASTHMA EPISODE? _____

FOR INHALED MEDICATIONS: (PLEASE HAVE HEALTH CARE PROVIDER SIGN/CHECK WHERE APPROPRIATE)

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

him/herself.

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

HEALTH CARE PROVIDER'S SIGNATURE DATE
DATE

PARENT/GUARDIAN SIGNATURE

COMMENTS: _____

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