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_____

PARENT/GUARDIAN_____________________

HOME PHONE#________________BUS.PHONE#_______________

CELL PHONE __________

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!

DAILY MEDICATION PLAN:

NAME RX          AMOUNT          WHEN TO USE

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 HUNCHES 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:

NAME OF MEDICATION       DOSAGE       ROUTE ADMIN.       WHEN TO USE

1. ________________________          ____________          ____________          ____________

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                PARENT/GUARDIAN SIGNATURE   DATE

COMMENTS: ____________________________________________

M-42 Rev 5/03