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!

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 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:

	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: _____

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