

DATE: _____

Asthma

Student Name: _____ Grade _____

Physician Name _____ Tel _____

How long has your child had asthma? _____

Please rate the severity of his/her asthma (circle)

(not severe) 0 1 2 3 4 5 6 7 8 9 10 (severe)

How often do the asthma attacks occur? _____

Has student been treated in the hospital for asthma in the past year? No Yes Dates _____

Is a peak flow meter used? No Yes. How often? _____ Best flow rate is: _____

Check any conditions that usually trigger an asthma episode:

- | | |
|--|---|
| <input type="checkbox"/> Respiratory infection | <input type="checkbox"/> Exercise (describe) _____ |
| <input type="checkbox"/> Exposure to cold air | <input type="checkbox"/> Odors (describe) _____ |
| <input type="checkbox"/> Emotional stress | <input type="checkbox"/> Allergic reactions to: _____ |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Other _____ |

Check the signs that are usually present during an asthma attack

- | | |
|---|---|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Short of breath |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Bluish color of skin/nails |
| <input type="checkbox"/> Feels frightened | <input type="checkbox"/> Other _____ |

What does your child do at home to relieve wheezing during an asthma attack?

- | | |
|--|--|
| <input type="checkbox"/> Breathing exercises | Take Medications: <input type="checkbox"/> Inhaler |
| <input type="checkbox"/> Rest/Relaxation | <input type="checkbox"/> Nebulizer |
| <input type="checkbox"/> Drink liquids | <input type="checkbox"/> Oral medication |
| <input type="checkbox"/> Other _____ | |

Please list below the medications your child takes for asthma:

Medication	Dose and Frequency	Taken at school ¹
		<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes
		<input type="checkbox"/> No <input type="checkbox"/> Yes

If medications are to be given during school, medication permission forms signed by the physician will need to be completed yearly. Medications must be in the original labeled container.

If your child does not respond to the above treatments or medication, what action do you advise school personnel to take? _____

Does your child need any special considerations related to his/her asthma while at school? _____

Please indicate any additional information you wish the school to know: _____

The usual procedure followed at school for asthma is:

1. Allow student to use prescribed asthma medication with assistance given as needed.¹
2. Encourage relaxation with slow deep breathing, sipping warm fluids.
3. Stay with student and monitor for symptoms
 - If symptoms decrease after 15 minutes, return to class.
 - If symptoms remain the same after 15 minutes, parent will be contacted for directions.
 - If symptoms increase in severity, will call 911, CPR will be started if needed, parents called.