ASTHMA

You have indicated **asthma** as a medical concern on your child's school records. It is important to have at least annual health information to best address the health needs of your child. **Please provide the information requested below and return it to school tomorrow** so that a plan to help your child can be shared with identified school personnel. It is the responsibility of parents to provide necessary medication, test equipment and special food needed at school. If you have questions please contact the school nurse.

Student's Name____ Date of Birth ____________________

Parent/ Guardian____ Telephone Number____________________________

Physician____ Telephone Number____________________________

How often do the asthma attacks occur?____

Has the 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 the conditions that trigger this student's asthma attack:

- ❑ respiratory infection (describe)____
- ❑ exercise
- ❑ exposure to cold air
- ❑ odors (describe)____
- ❑ emotional stress
- ❑ allergic reactions to ____
- ❑ smoking
- ❑ other ____

Check signs usually present in this student's asthma attack:

- ❑ coughing
- ❑ bluish color of skin/ nails
- ❑ wheezing
- ❑ unable to speak sentence without taking a breath
- ❑ feels frightened
- ❑ other ____
- ❑ shortness of breath

Does student have restrictions regarding physical activity?* (i.e. exercise limits; ❑No ❑Yes (Describe)_______________________

Are medications needed to control asthma? ❑No ❑Yes (list below the medications needed)

Medication	Amount Taken	Time of Day
1.		
2.		
3.		
Circle the number of any of these medications to be taken at school. ** **ADVISE THE SCHOOL NURSE IMMEDIATELY OF CHANGES IN DOSE AND/ OR TYPE OF MEDICATION.**		

<u>The usual procedure at school for asthma is:</u>

1. **Allow student to use his or her prescribed asthma medication** with assistance given as needed.**
2. **Encourage student to relax with slow deep breathing, sipping warm fluids.**
3. **Stay with student and monitor for symptoms:**
   If symptoms decrease after 15 minutes, student may return to class.
   If symptoms remain the same after 15 minutes, parent will be contacted for directions.
   If symptoms increase in severity, call 9-1-1. CPR will be started if needed. Parents called.

(OVER)

If you want additional help given, or have other concerns, describe here: *
____

____

X____

Parent Signature **Date**

*Treatments or tests and activity restrictions require written direction from the student's doctor or primary care provider. Equipment and snacks will be provided by parent.

**The district medication policy requires parental and physician signatures on district forms for all prescription medications administered during school activities. Forms are available in the school office.

For RN Use Only

Nsg Dx
- ❑**Stable Hx**
- ❑**Potential Complication: hypoxemia**
- ❑**High Risk for ineffective breathing pattern**

Outcome goal
- ❑**Student will maintain optimum breathing pattern during 100% of school day.**

Plan
- ❑**Standard Procedure for Asthma**
- ❑**Standard Medication Procedure**
- ❑ **Other** ____
- ❑**Individualized EAP**
- ❑**Delegation**

Evaluation
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RN:___________________________ **Date:**______________________

Annual Review:

Date:______________________ Date:______________________
RN:______________________ RN:______________________
Parent:______________________ Parent:______________________