DISTRICT 4J SCHOOLS
HEALTH SERVICES

Student Name _____ School _____

Date of Birth _____ Date _____ Grade _____

ASTHMA ASSESSMENT and CARE PLAN

You have checked on school records that this student has **asthma**. It is important to have current health information & direction when she/he needs help at school. Please complete this form & return it to your child's school so that appropriate instructions may be given to school personnel. Your school nurse is available for consultation.

How often do the asthma episodes occur? _____

Most recent asthma related hospitalization/emergency room visit._____

Name of the doctor who is currently treating student's asthma: _____ _____
(Dr's phone #)

Does your child ride the school bus? ___No ___Yes Bus No. _____

Does your child participate in school sports? ___No ___Yes

LIST THE CONDITIONS THAT USUALLY BRING ON THIS STUDENT'S ASTHMA EPISODES:

___ Emotional stress ___ Respiratory Infection ___ Exposure to Cold Air

___ Exercise (describe, e.g., after running) _____ ___Odors (describe) _____

___ Allergic reaction (describe: e.g., peanuts, carpets) _____

WHAT SYMPTOMS ARE USUALLY PRESENT IN THIS STUDENT'S ASTHMA EPISODES:

____ Coughing ____ Wheezing ____ Shortness of Breath ____ Fear ____ Bluish Color of Skin/Nails

____ Unable to speak a sentence without taking a breath, ____Other (describe) _____

ARE MEDICATIONS NEEDED TO CONTROL THE ASTHMA? ___No ___Yes (List below the medications needed)

MEDICATIONS	**AMOUNT TAKEN**	**WHEN AND FOR WHAT SIGNS?**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

(Circle number of any of these medications to be taken at school.)

Is student capable of self-administering rescue inhaler? Yes____ No___
Where is rescue inhaler kept? _____ (K-8 school office recommended)
If you want the school nurse to be aware of other comments or special directions, list them here:

THE USUAL CARE PLAN AT SCHOOL FOR A STUDENT'S ASTHMA IS:

1. Assist student with prescribed medication and allow to rest.
2. Encourage student's relaxation (e.g., slow, deep breathing, sipping warm fluids).
3. Observe student for inadequate breathing; call 911/EMS if inadequate breathing is observed.
4. Call parent if medication is not helping or student is using rescue inhaler a second time in a day.

If you want additions or changes to this, please describe:_____

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Student Name_____

Parent/Guardian Contact #1	Emergency Contact #2	Emergency Contact #3
Name _____	Name_____	Name_____
Relationship_____	Relationship_____	Relationship_____
Address_____	Address_____	Address_____
Phone: (H)_____(W)_____	Phone: (H)_____(W)_____	Phone: (H)_____(W)_____
Cell_____	Cell_____	Cell_____

AMBULANCE PERMIT

I give consent for the school principal, school nurse, or other school personnel to use their judgment in securing further medical aid and to call an ambulance to take my (son, daughter) _____ to _____Hospital in case parent/legal guardian cannot be reached.

The above information may be shared with ambulance personnel. **PERMISSION:___YES___NO**

To provide for your child's safety and educational experience the above information will be shared with school staff, included in your child's school health record and may be shared electronically.

_____ _____

Signature of Parent/Guardian Date (Valid One Year)

RETURN THIS FORM TO THE SCHOOL

	DATE	SIGN / INITIAL
STUDENT COMPUTER SYSTEM ENTRY	_____	_____
INFORMATION SHARED WITH STAFF	_____	_____

Additional notes:_____

_____

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