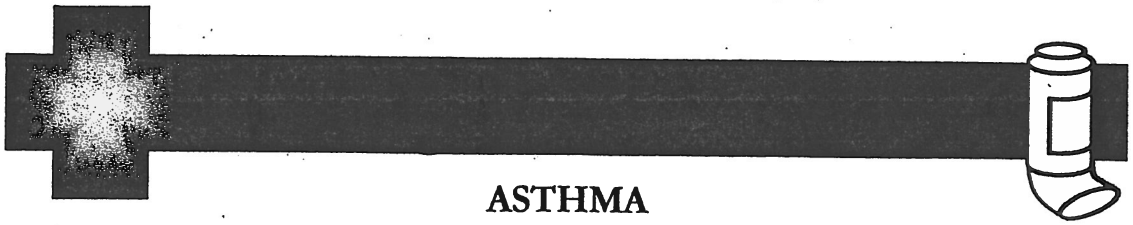

ASTHMA

Student: _____ Grade: _____ School Contact: _____ DOB: _____

Asthma Triggers: _____ Best Peak Flow: _____

Mother: _____ MHome #: _____ MWork #: _____ MCell #: _____

Father: _____ FHome #: _____ FWork #: _____ FCell #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SYMPTOMS OF AN ASTHMA EPISODE MAY INCLUDE ANY/ALL OF THESE:

- **CHANGES IN BREATHING:** coughing, wheezing, breathing through mouth, shortness of breath, Peak Flow of < _____.
- **VERBAL REPORTS of:** chest tightness, chest pain, cannot catch breath, dry mouth, "neck feels funny", doesn't feel well, speaks quietly.
- **APPEARS:** anxious, sweating, nauseous, fatigued, stands with shoulders hunched over and cannot straighten up easily.

Student Photo

SIGNS OF AN ASTHMA EMERGENCY:

- Breathing with chest and/or neck pulled in, sits hunched over, nose opens wide when inhaling. Difficulty in walking and talking.
- Blue-gray discoloration of lips and/or fingernails.
- Failure of medication to reduce worsening symptoms with no improvement 15 – 20 minutes after initial treatment.
- Peak Flow of _____ or below.
- Respirations greater than 30/minute.
- Pulse greater than 120/minute.

STAFF MEMBERS INSTRUCTED:

❑ Classroom Teacher(s) ❑ Special Area Teacher(s)
❑ Administration ❑ Support Staff ❑ Transportation Staff

TREATMENT:

Stop activity immediately.
Help student assume a comfortable position. Sitting up is usually more comfortable.
Encourage purse-lipped breathing.
Encourage fluids to decrease thickness of lung secretions.
Give medication as ordered: _____
Observe for relief of symptoms. If no relief noted in 15 – 20 minutes, follow steps below for an asthma emergency.
Notify school nurse at _____ who will call parents/guardian and healthcare provider.

STEPS TO FOLLOW FOR AN ASTHMA EMERGENCY:

- Call 911 (Emergency Medical Services) and inform the that you have an asthma emergency. They will ask the student's age, physical symptoms, and what medications he/she has taken and usually takes.
- A staff member should accompany the student to the emergency room if the parent, guardian or emergency contact is not present and adequate supervision for other students is present. Preferred Hospital if transported: _____

Healthcare Provider: _____ Phone: _____

Written by: _____ Date: _____

❑ Copy provided to Parent ❑ Copy sent to Healthcare Provider

Parent/Guardian Signature to share this plan with Provider and School Staff: _____

This plan is in effect for the current school year and summer school as needed.

Revised 1/08

AMERICAN LUNG ASSOCIATION®

ASTHMA HISTORY FORM

Student's Name: _____ Date of Birth: _____

History Taken by: _____ Date: _____

Parent/Guardian Name: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Alternate Contact: _____ Phone: ( ) _____

Primary Health Care Provider: _____ Phone: ( ) _____

Address: _____

When was this student's asthma first diagnosed? _____

How many times has this student been seen in the emergency room for asthma in the past year? _____

How many times has this student been hospitalized for asthma in the past year? _____

Has this student ever been admitted to an intensive care unit for asthma? _____
When? _____

How would you rate the severity of this student's asthma?

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

How many days would you estimate this student missed last year because of asthma? _____

What triggers this student's asthma?

- ❑ exercise
- ❑ respiratory infection
- ❑ strong odors or fumes
- ❑ stress
- ❑ cigarette smoke
- ❑ wood smoke
- ❑ pollen
- ❑ animals (specify): _____
- ❑ foods (specify): _____
- ❑ carpets
- ❑ indoor dust
- ❑ outdoor dust
- ❑ chalk dust
- ❑ temperature changes
- ❑ molds
- ❑ other: _____

What does this student do at home to relieve asthma symptoms (check all that apply)?

- ❑ breathing exercises
- ❑ rest/relaxation
- ❑ drinks liquids
- ❑ takes medications (see below)
- ❑ uses herbal remedies (see below)
- ❑ other (please describe): _____

ASTHMA HISTORY FORM

What medications does this student take for asthma (every day and as needed):

Medication Name	Amount	Delivery Method (nebulizer, inhaler, etc.)	How Often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What herbal remedies, if any, does this student take for asthma? _____

_____

Does this student use any of the following aids for managing asthma?

- ❑ peak flow meter (personal best if known _____)
- ❑ holding chamber ❑ spacer ❑ holding chamber w/mask
- ❑ other: _____

Please check special needs related to your child's asthma:

- ❑ physical education class ❑ recess ❑ animals in classroom
- ❑ avoidance of certain foods ❑ field trips ❑ access to water
- ❑ transportation to and from school ❑ other
- ❑ observation of side effects from medications

If you checked any of the above boxes, please describe needs:

_____

_____

Has this student had asthma education? ❑ yes ❑ no
Would you like information about asthma education for: ❑ student ❑ self

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____