Asthma Information

Name:______________________________ DOB:______________
Student # ______________
Teacher:______________________________ Room:______________
Parent/Guardian:____________________________ Ph:(H)______________
Ph:(W)______________
____________________________ Ph:(H)______________
Ph:(W)______________
Physician:______________________________ Ph:______________
Hospital Preference: ____

School ID Photo (school will provide if available)

Emergency Contact #1:______________________ Relationship:____________ Ph:__________
Emergency Contact #2:______________________ Relationship:____________ Ph:__________

1) What triggers your child's asthma? (Check all that apply)

O *Animals*	O *Carpets*	O *Chalk dust*
O *Cold weather*	O *Exercise*	O *Food*
O *Molds*	O *Pollen*	O *Respiratory infections*
O *Smoke*	O *Stress or emotions*	O *Strong odors or fumes*
O *Other*	O *Other*	O *Other*

Comments:____

2) What are your child's early warning signs of an asthma episode? (Check all that apply)

O *anxiety*	O *change in breathing*	O *coughing*
O *cold symptoms*	O *decreased energy*	O *drop in peak flow reading*
O *tightness in chest*	O *wheezing*	O *other*

3) Does your child understand her/his triggers and how to avoid them if possible?
____

4) When unable to avoid the triggers, does your child use medication to pre-treat? (for example, use an inhaler prior to exercise, being around animals, etc.) ____________________

5) Does your child use a Peak Flow Meter at home? ______________ If yes, what is her/his Personal Best Peak Flow number:__________(Green Zone Peak Flow Rate)

6) List your child's *daily* (not acute episode) medications (Green Zone, controller medicine(s):

1)		
2)		
3)		
4)		

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Please complete the other side of this form for an Emergency Action Plan to be used if your child has an asthma episode at school.

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Asthma Emergency Action Plan*
for (Name)_________________

***May supplement an Individualized Education Plan (IEP) or 504 Plan**

Steps to take during an asthma episode:

1) Give medication(s) (as listed below; student may carry own inhaler, but is responsible for having an unexpired inhaler at all times.)
2) Have student return to classroom if_________________________ ____
3) Contact parent if ____
4) ***Call 911 if student has any of the following:***

⇒ ***No improvement 15-20 minutes after initial treatment with medication and parent/guardian cannot be reached***

⇒ ***Peak flow number of ________ or below (Red Zone Peak Flow Rate)***

⇒ ***Hard time breathing as evidenced by:***

√ ***Chest and neck pulled in with breathing***

√ ***Child is hunched over***

√ ***Child is struggling to breathe***

⇒ ***Trouble walking or talking***

⇒ ***Stops playing and can't start activity again***

Acute Asthma Episode/Emergency Medications

Name of Medication	Amount	When to Use
1)		
2)		
3)		
4)		

Special Instructions or Comments ______________________________ ____

Date____________ Parent _____________________________________

Date____________ Health Care Provider_________________________

Date____________ Nurse_______________________________________

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Please complete the other side of this form to provide us with important information about your child's asthma.

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