

**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)

<u>MEDICATIONS</u>	<u>AMOUNT TAKEN</u>	<u>WHEN AND FOR WHAT SIGNS?</u>
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:

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**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: \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_