Student ______________________________ Date of Birth __________ Grade _________

Asthma Questionnaire/Individual Health Plan

School Year_________

Please complete and return to the School Nurse. The following information is helpful in determining any special needs.

Person to contact:	Relationship:	Work Phone:	Home Phone:
1. ______________	______________	______________	______________
2. ______________	______________	______________	______________
3. ______________	______________	______________	______________
4. ______________	______________	______________	______________
Family Physician:	Clinic:	Phone:	
______________	______________	______________	
Hospital:	Phone:		
______________	______________	Health Insurance: _____Yes _____No	

Child's age at diagnosis of asthma ______

How severe is your child's asthma? _____ Mild _____ Moderate _____ Severe

Please check what usually triggers (starts) your child's asthma attack/episode.

_____ exercise _____ infection _____ animals/pets _____ chalk/chalk dust
_____ cold air _____ stress _____ grass/flowers _____ strong smells/perfume
_____ smoke _____ dust/dust mites _____ mold
_____ allergies to ____
_____ other ____

Student knowledgeable about asthma triggers? ___ Yes ___ No

When does your child typically have asthma symptoms? ___ Fall ___ Winter ___ Spring ___ Summer
___ Daily ___ Weekly ___ Monthly ___

Please check your child's usual signs/symptoms of an asthma attack/episode.

_____ wheezing
_____ difficulty breathing
_____ coughing
_____ chest tightness
_____ emotional/behavior changes - please explain ______________________________
_____ other ____

Does he/she recognize these signs? YES NO

In the past year, how often has your child been treated for asthma in the emergency room?_____________________
overnight in the hospital?_____________________

Please check what your child does to relieve wheezing during an asthma attack/episode.

_____ Loosens clothing _____ Abdominal (belly) breathing
_____ Relaxation exercises _____ Sips warm fluids
_____ Uses peak flow meter _____ Other ______________________________
_____ Takes medication:

As Needed:

Name of Medication	Amount Taken	How Taken	How Often
______________	______________	______________	______________

Routine (on a regular basis):

Name of Medication	Amount Taken	How Taken	How Often
______________________	______________________	______________________	______________________
______________________	______________________	______________________	______________________

Child carries own inhaler ___Yes ___No Located:____

Does your child know when he/she needs medication? YES NO

Please list any side effects of your child's medications that may affect his/her learning and/or behavior.

____

Please check what your child should do to **prevent** an asthma attack/episode.

_____ cover nose and mouth in cold weather
_____ use inhaler before exercise
_____ avoid contact with animals in classroom
_____ avoid known allergens (allergies), list ____
_____ other (list)____

Does your child know how to use a peak flow meter? YES NO

What is your child's baseline peak flow meter reading? ____

If a medication is to be given at school, a medication form must be completed yearly. The medication must be in original labeled container. (When you get the prescription filled, please ask the pharmacist to put it into two containers so your child will have one for school and one for home use.)

What action do you want school personnel to take, if your child does not respond to treatment/medication?
____

Are there any classroom or physical education accommodations needed for your child?
____

In an acute emergency the student will be transported by ambulance to the hospital. Transportation in a non-acute situation is the responsibility of the parent/guardian. Any charges incurred are the responsibility of the parent/guardian.

Please add anything else you would like school personnel to know about your child's asthma.

____

Emergency Plan:

- **Signs of Emergency:**
- **Difficulty breathing**
- **Difficulty talking**
- **Blue or gray discoloration lips or fingernails**
- **Failure of medication to reduce worsening symptoms**
- **Other ___________________________________**

Action for Non-Nursing Personnel:

- **Use medication (see medication listing)**
- **Notify school nurse and office**
- **Loosen clothing**
- **Encourage relaxation**
- **Encourage abdominal (belly) breathing**
- **Administer warm water**
- **Delegate another adult to call parent/guardian**
- **Call 911 if needed**
- **Other ___________________________________**

Nursing Diagnosis	Goal	Plan
1. Potential for ineffective breathing pattern.	Student will manage the symptoms of asthma as directed.	◆Health services personnel will dispense or supervise medication administration while at school. ◆Student will demonstrate correct use of inhaler/nebulizer/peak flow meter if age appropriate.
2. Potential for activity intolerance.	Student will self limit activities as	◆Parents will provide written physician

	needed and attend school regularly.	orders for limitations when necessary for extended periods of time. ◆Health services personnel will notify teacher/staff of any activity restrictions.
3. Potential for knowledge deficit of disease.	Student will understand the triggers, early signs, and when to seek assistance in the health room.	◆School Nurse (SN) will train teachers and work with student to be aware of early warning signs and actions needed to prevent or respond to an episode. ◆The student will come to the health room for medication and/or assistance as needed.
4. Potential for non-compliance.	Student will maintain health and prevent life-threatening emergencies.	◆SN/Health aide will notify parent(s) of any changes in student's compliance in taking prescribed medication and reporting asthma symptoms.
5. Potential for side effects related to medication.	Student, parents and staff will identify common side effects that may affect educational performance.	◆The health services personnel will make this information available to staff.

Plan initiated:

Date/Grade: ______________________ Signature: ____

Plan reviewed/updated:

Date/Grade: Signature:

______________________ ____
______________________ ____
______________________ ____
______________________ ____
______________________ ____
______________________ ____

Date: Copy Given To:

______________________ ____
______________________ ____
______________________ ____
______________________ ____

___ Student/child has participated in the development and implementation of this asthma plan and aware of the components of the plan.

School nurse may share this information with appropriate school personnel YES NO

I authorize reciprocal release of information related to asthma between the school nurse and the health care provider.

____

Parent/Guardian Signature Date