

Student Name _____ Birthdate _____ Today's Date _____
 Parent Name _____ Health Care Provider _____

Dear Parent/Guardian,
 Please complete and return this form to the Healthroom so that school and health staff can better assist your child manage his/her asthma. **All students who have medications for asthma management at school must have this form completed by a parent or guardian or have an asthma action plan completed by the health care provider.**

When my child has an asthma episode, he/she has the symptoms circled below:

- | | |
|--------------------------|-----------------|
| Shortness of breath | Rapid breathing |
| Blue or gray lips | Anxiety/Panic |
| Coughing | Wheezing |
| Blue or gray finger tips | Dizziness |
| Other _____ | |



When my child has an asthma episode, it may be caused by the items circled below:

- | | |
|---|-------------------------|
| Smoke | Mold |
| Cockroaches | Stress/emotional upsets |
| Animals/pets | Strong smells/perfume |
| Dust/dustmites | Respiratory illness |
| Grass/flowers | Chalk/chalk dust |
| Weather changes/very cold or very hot air | |
| Foods _____ | |

My Child:

- Is seen regularly by a health care provider to monitor asthma Yes No
- Needs emergency medication two or more times per week Yes No
- Wakes up at night coughing two or more times per month Yes No
- Was seen in Emergency Room due to asthma in the past year Yes No
- Was hospitalized due to asthma in the past year Yes No

My Child:

- Uses a spacer with medication administered by an inhaler Yes No
- Uses a peak flow meter to monitor his/her asthma Yes No
- Has a normal peak flow reading of _____
- Needs emergency medication when the peak flow reading is less than _____
- Needs medical attention when the peak flow reading is less than _____

My Child's Name _____

My child's medications are:

Control/maintenance/daily medication(s):

Name _____ Amount & How often to be given _____

Name _____ Amount & How often to be given _____

Name _____ Amount & How often to be given _____

Name _____ Amount & How often to be given _____

Management at School

When my child has an asthma episode at school, health/school staff should do the following:

Permit student to rest in health room Yes No

Administer prescribed emergency medication Yes No
(needs Medication order, MCPS 525-13)

Permit student to carry inhaler to self-administer rescue/emergency medication Yes No
(needs Medication order, MCPS 525-13)

Call parent/guardian/emergency contact Yes No
(as indicated on school emergency card)

Call 911 Yes No

Other _____

This information will be shared with school staff with a need to know.

Parent/Guardian Signature _____ Date _____

Reviewed by _____, **School Community Health Nurse**

Date _____

Comments

stay healthy