

FORT ZUMWALT SCHOOL DISTRICT
ASTHMA ASSESSMENT GUIDE

Date: _____

STUDENT: _____

Parents' telephone numbers:

Mom's Name: _____ (H) _____ (W) _____

Dad's Name: _____ (H) _____ (W) _____

Other emergency contact:

Name: _____ Telephone: _____

Doctor/health care provider:

Name: _____ Telephone: _____

Other Physician: _____ Telephone: _____

DAILY ASTHMA MANAGEMENT PLAN

**** Identify the things which start an asthma episode (Check each that applies to the student.)**

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Strong odors or fumes | <input type="checkbox"/> Pollens |
| <input type="checkbox"/> Respiratory infections | <input type="checkbox"/> Chalk dust | <input type="checkbox"/> Molds |
| <input type="checkbox"/> Change in temperature | <input type="checkbox"/> Carpets in the room | <input type="checkbox"/> Animals |
| | | <input type="checkbox"/> Other _____ |

Comments: _____

**** Control of School Environment**

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

**** Peak Flow Monitoring**

Personal Best Peak Flow number: _____

Monitoring Times: _____

**** Daily Medication Plan**

	<i>Name</i>	<i>Amount</i>	<i>When to Use</i>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____, _____, _____, _____, or has a peak flow reading of _____.

**** Steps to take during an asthma episode:**

1. Give medications as listed below.
2. Have student return to classroom if _____
3. Contact parent if _____
4. *Seek emergency medical care if the student has any of the following:*
 - No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
 - Peak flow of _____.
 - Hard time breathing with:
 - * 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
 - Lips or fingernails are gray or blue

**** Emergency Asthma Medications**

	<i>Name</i>	<i>Amount</i>	<i>When to Use</i>
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments/Special Instructions

For Inhaled Medications

- I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.
- It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

Physician Signature: _____

Date: _____

Parent Signature: _____

Date: _____