THIS FORM MUST BE UPDATED ANNUALLY

Picture

ASTHMA

Questionnaire and Emergency Care Plan 2021-22

We have report that your child has a breathing problem or some form of asthma.
Please help us to understand the details of his/her condition, now referred to as "episodes."
If this has been a problem in the past, but is no longer a current concern, please sign below so that your child's health record can be updated.
Parent/Guardian name: _____

Student's name_____ Date of Birth_____ Grade/Teacher_____

Parent/Guardian_____ Home phone_____ Cell _____

Address _____ Work phone (Mom) _____ (Dad)_____

City: _____ **Physician name**_____ Phone_____

Hospital preference (if 911 transport needed) _____ In the event of an emergency, contact with a parent/guardian will be attempted first; before transfer occurs.

1. At what age did your child have his/her first episode? _____
b. How severe was the first episode? (circle) ☐ **MILD** ☐ **MODERATE** ☐ **SEVERE** Emergency Department or hospital care ☐ **YES** ☐ **NO**
c. When was the last time your child experienced an episode? (date):_____
d. How severe was this last episode? (circle) ◯ **MILD** ◯ **MODERATE** ◯ **SEVERE**
e. If applicable, how many episodes required either hospital or Emergency Department care during the past year? _____
f. How many days did your child miss school last year due to his/her asthma: _____ days
g. During the past year, has your child's asthma ever prevented him/her from taking part in sports, recess, physical education or other such activities? ☐ **YES** ☐ **NO** ☐ Don't Know

2. Does your child have any other known allergy or other triggers ☐ **YES** ☐ **NO** If so, please circle:

Smoke	Animals/pets	Dust/dust-mites	Cockroaches
Grass/flowers	Mold	Chalk/chalk dust	Strong smells/perfume
Stress or emotional upset		Changes in weather/very cold or hot air	
Having a cold/respiratory illness		Exercise, sports, or playing hard	
Foods (which ones): _____		Any other triggers: _____	

3. Has your child had allergy testing by a medical clinic? (circle) ☐ **SKIN** ☐ **BLOOD** ☐ **None**
b. Does your child know what triggers to avoi ☐ **YES** ☐ **NO**
c. Have any allergy shots been starte ☐ **YES** ☐ **NO** Please list types:_____
d. Does anyone in the household smoke? _____ If yes, where: _____

4. What are the pre-warning signs (physical & emotional changes) that indicate that your child may be having an asthma episode?

_____

a. What are the signs that indicate that your child is having an actual episode? (ie. Wheezing, cough without relief, respiratory difficulty) Explain: _____

_____

b. Does your child recognize when he/she is having an episode? (circle) ☐ **YES** ☐ **NO**

Medications taken at Home

Medication name	How much and how often?	When is it taken?

Student name:_____ Date of Birth: _____

For Health Care Provider: Please complete this section:

Medications to be taken at School

Medication name	How much and how often?	When is it taken?

5. **School management of asthmatic episode**: be specific: (ie: bronchodilator before physical activity or cold weather recess; scheduled times vs. prn; Additional medications during illness.) **Please describe further (attach additional sheets if needed) in order for the school to response appropriately.**

_____

a. Does the student know when medication is needed? ☐ YES ☐ NO b. Spacer required for their inhaler ☐ YES ☐ NO
c. Is student inhaler proficient ☐ YES ☐ NO Neb form needed ☐ YES ☐ NO Does student need assistance ☐ YES ☐ NO

In order for student to carry their own medication at school, the student self-administration form needs to be filled out, available on our website.

Any other comment:_____

Physician/NP/PA signature _____ Date _____

6. At what point do you want the school to contact you, as parents, regarding your child's breathing episode? _____

7. If your child continues in distress, what action do you advise the health office to take? _____

_____

8. If there anything else you would like to add about your child's breathing? _____

_____

I request that the above medication(s) be given during school hours or while on field trips for the above mentioned condition as ordered by my child's physician/licensed provider. I will notify the school of any change in the medication (dosage changes, or stopping of medication, etc.) I give permission for the school nurse to consult with the above student's physician/licensed prescriber regarding any questions that arise with regard to the listed medical condition and medication if used. Medications must be in their original containers, clearly labeled with the child's name and directions for giving the medication. Legally you may refuse to sign for the medication. If you refuse to sign we will not be able to administer the medication by school personnel. This consent may be revoked, at any time, by sending a written note to the licensed school nurse. This information will not be released to any third party payer.

Parent/Guardian signature _____ Date _____

In case of breathing difficulties:

Symptoms (If you see this):	**Actions to Take (Do this):**
Breathing difficulties	Remain calm, reassure and stay with the child
Unusually fast or slow breathing	Give medication as ordered on top of this form
Unusually deep or shallow breaths	Notify school health office as soon as able
Gasping for breath, wheezing or coughing	Have student sit up and breathe evenly, breathing in through nose and breathing out through pursed lips
Appears or reports feeling short of breath	Give sip of room-temperature water
Difficulty talking or walking	Elevate arms to shoulder level and provide support for arms (desk or back of chair)
Tightness in chest, upset stomach, restless or anxious	**Notify 9-1-1**, parent/guardian, school nurse, if not improving
Blue or gray discoloration of lips or fingernails	

WHEN TO CALL 911

If no improvement 5-10 minutes after using medication or no medication available
If worsening breathing symptoms:
Child is struggling to breathe;
Lips or fingernails are gray or blue
Chest and neck pulled in with breathing
Trouble walking or talking
Increasing anxiety, confusion