ASTHMA MANAGEMENT **NAME**_____ **DATE** _____
Initial Assessment **DOB**_____ **Grade/Teacher:** _____

The following will assist the school nurse and staff in determining any special needs for your child. If you desire a conference with the school nurse, please call your child's school for an appointment.
For use by the clinician to guide the assessment of a child with symptoms suggestive of asthma

ASTHMA/RESPIRATORY HISTORY:

1. Symptoms (does your child have?):

___Daytime cough ___Daytime wheezing ___Shortness of breath ___Chest tightness ___Sputum production
___Nighttime cough ___Nighttime wheezing ___Interrupted sleep due to symptoms

2. Patterns of Symptoms

___Perennial (yearly), seasonal, or both (please describe)_____
___Continual, episodic, or both (please describe) _____
___Daily variations, esp. nightly & on awakening in early morning _____
Onset of symptoms, duration, frequency (# of days or nights per week or month) _____
_____

3. Precipitating and/or aggravating factors (Triggers)

___Viral respiratory infections ___Environmental allergens (indoors/outdoors)
___Exercise ___Irritants (tobacco smoke, strong odors, chemicals)
___Changes in weather, exposure to cold air ___Animal dander or feathers
___Foods, food additives, food preservatives ___Emotional expression (fear/anger/crying/laughing)
___Drugs (aspirin, NSAIDs, beta-blockers including eye drops, others)
___Other_____
*IF CHECKED ANY ABOVE PLEASE DESCRIBE: _____
_____
_____

4. Development of disease and management/treatment

Age of onset of Asthma_____
Use of peak flow meter (frequency, current readings) _____
Present medications (name, dosage, & frequency) _____
_____
Need for oral corticosteroids and frequency of use_____
How many times in the past year has your child been treated in the doctor's office for asthma: _____
Date of last Doctor's appointment: _____ Date of Last Pulmonary Function Test: _____
Physician Treating Asthma: _____ Phone Number: _____

<u>Episodes of unscheduled care</u>: (date of service and how long or how many times in past year)

- Hospitalization_____
- Emergency Room_____
- Urgent Care Clinic_____

<u>Life-threatening events</u>:

- Intubation_____ ICU admission_____

<u>Typical Asthma Symptoms</u>:

- Frequency_____
- Usual signs/symptoms_____
- Usual patterns (Describe what happens) _____
  _____
- Management (what works?)_____

_____

CONTINUED ON REVERSE

- Number of days missed from school (also parents from work) due to asthma symptoms_____
  _____
- Limitations of activity_____
- Effect on growth, development, school (do you expect asthma to impact? And how?)_____
  _____

5. Social history (of the student/family)

Members of household_____
_____

Family members with health problems_____
_____

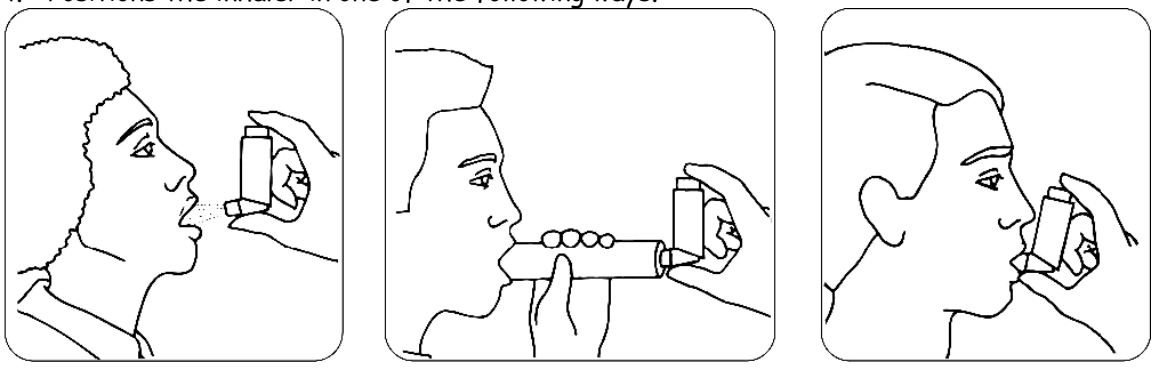
Smoking in the home: ☐ Yes ☐ No
Pets in the home: ☐ Yes ☐ No Type: _____

6. **Child knowledge of condition:**

Does your child understand asthma triggers, and reliably reports any difficulty? ☐ Yes ☐ No
Comments: _____
Does your child know how to utilize their inhaler properly? ☐ Yes ☐ No
Did your physician instruct your child on proper use of the inhaler? ☐ Yes ☐ No

Steps for using a Metered Dose Inhaler Correctly:

1. Places canister in the mouthpiece and removes the cap
2. Shakes the metered dose inhaler (MDI) unit rapidly for 3 seconds
3. Tilts head back slightly and breathes out.
4. Positions the inhaler in one of the following ways.



5. Presses down on the inhaler to release medication as they start to breathe in slowly.
6. Breathes in slowly (3-5 seconds).
7. Holds breathe for 10 seconds to allow medication to reach deeply into lungs.
8. Repeats puffs as directed. Waits <u>1 minute</u> between puffs to permit the second puff to penetrate the lungs better.
9. Rinse mouth with water afterward.

Please keep my child's teacher and staff that may be involved with my child updated on his/her asthma care. I also give the nurse permission to speak with his/her doctor as needed along with parent notification. I am aware that if an Emergency Care Plan is indicated by the nurse, that it will need to be updated yearly.

Parent Signature _____Date_____

Nurse Referral for Emergency Care Plan: ☐ Yes ☐ No

Nurse Signature:_____Date_____