NOTE: Parents are to provide the physician's medical management plan to the school ***annually.*** The medical orders, along with the health intake below, assist the school nurse in developing an Individual Healthcare Plan for the student.

Student's Name: _____ **DOB:** ___/___/____ **Grade:** _____ **Today's Date:** ___/___/____

Parent/Guardian 1: _____ **Contact Information:** _____

Parent/Guardian 2: _____ **Contact Information:** _____

Name of physician treating student's asthma: _____ **Phone Number:** _____

Health Insurance: ☐ Private ☐ Medicaid/KanCare ☐ Currently without insurance

Medical alert jewelry worn? ☐ Yes ☐ No **IEP?** ☐ Yes ☐ No **Current 504 Plan?** ☐ Yes ☐ No

Mode of transportation to and from school? _____

Does student participate in before or after school activities? ☐ Yes ☐ No

Student's age of onset of asthma symptoms? _____ **Age at diagnosis of asthma?** _____

What symptoms does student display during an asthma episode? (Please check all that apply):

☐ Wheezing ☐ Coughing ☐ Shortness of breath ☐ Chest tightness

☐ Other (Please list):_____

During the day, how often does student have a hard time with coughing, wheezing, or breathing?

☐ 2 times a **week** or less ☐ More than 2 times a **week** ☐ **All the time**, throughout the day, every day

During the night, how often does student wake up or have a hard time with coughing, wheezing, or breathing?

☐ 2 nights a **month** or less ☐ More than 2 nights a **month**

☐ More than 2 nights a **week** ☐ More than 4 nights a **week**

How much does student's asthma bother or interrupt normal activities (playing, sports, running around)?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ All of the time

How many times has student been to the emergency room or hospitalized for asthma in the past year?

☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 times ☐ 5 or more times

How many days did student miss school last year for asthma symptoms (wheezing, coughing, shortness of breath?)

☐ 0 days ☐ 1-2 days ☐ 3-5 days ☐ 6-9 days ☐ 10-14 days ☐ 15 or more days

Does the student also have a life-threatening allergy or anaphylaxis? ☐ No ☐ Yes _____

What triggers the student's asthma, or what makes symptoms worse? (Please check all that apply)

☐ Animals/Pets ☐ Changes in weather/cold or heat ☐ Dust/dust mites ☐ Smoke

☐ Stress/emotional upset ☐ Mold ☐ Grass/flowers ☐ Strong smells/perfumes ☐ Illness/colds

☐ Other (Please list):_____

Does the student use a peak flow meter? ☐ Yes ☐ No

If yes, what is his/her personal best peak flow number? _____

Does the student have an Asthma Action Plan (AAP), written by a healthcare provider? ☐ Yes ☐ No

If yes, has a copy of the AAP been brought to school? ☐ Yes ☐ No

Does anybody in the household smoke? ☐ Yes ☐ No

Please write the names or colors of medicines (inhalers/puffers, pills, liquids, nebulizers) **the student takes for asthma and allergies** (both every day and as-needed medicines)

Name of medication	Color of medication (Inhaler)	DAILY or AS NEEDED?

How well does the student take his/her asthma medications? (Check only one answer)

☐ Takes medicine by self ☐ Needs help taking medicine ☐ Not currently using medicine

Equipment and supplies provided by parent (indicate for each supply listed):

	Stays at school	Home to school each day
Daily Asthma Medications		
Peak Flow Meter		
Spacer for Metered Dose Inhaler		
Nebulizer/Tubing/Mask		

Does your student have family, peer, and community support systems? ☐ Yes ☐ No

Describe your student's response and current coping/adaptation to having asthma:_____

_____

Does your healthcare provider recommend your student self-carry and administer his/her own inhaler?

☐ Yes ☐ No

NOTE: Prior to self-carry/administration, the student's ability must be assessed by the school nurse and other required paperwork received per school district medication policy (e.g. healthcare provider order, self-carry administration form).

Parent/Guardian Signature: _____ **Date:** _____