

**Moberly School District
Health Services FY2011 School Year
School Asthma History and Needs Assessment**

Student Name: _____ **Grade:** _____ **Date of Birth:** _____

How long has your child had asthma? _____

What signs and symptoms signal a flare up of your child's asthma _____

Child's personal best peak flow number is _____

Green Zone (80-100% Personal Best) _____

Yellow Zone (50-80% Personal Best) _____

Red Zone (Below 50% Personal Best) _____

How many times has your child been taken to an ER due to asthma? _____ When? _____

How many times has your child been placed in the hospital due to asthma? _____ When? _____

How many days of school did your child miss due to asthma last year? _____

Describe any special care your child requires at school _____

Any dietary restrictions to follow at school _____

Describe the plan of care in the event of field trips, after-school activities and exercise _____

Equipment and Supplies Provided by Parents: _____ Daily Asthma Medications
_____ Emergency Asthma Medications
_____ Peak Flow Meter Supplies
(with mouthpiece)
_____ Spacer for Meter Dose Inhaler Use

Please list asthma and allergy medications that your child takes at home:

I rate my child's need for additional knowledge about asthma as:

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my child's need to improve skills for self-management of asthma (use of inhalers, peak flow meters, symptom reporting) as:

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my child's health problems related to asthma currently as (Optional: See Asthma Control Tool)

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate my level of concern about asthma posing a safety risk for my child at school:

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

I rate MY need for additional asthma information as:

0-None 1-Very Low 2-Low 3-Moderate 4-High 5-Very High (please circle one)

Asthma Needs Score: _____ (sum of item scores)

Person Interviewed _____ Date _____

Signature of School Nurse _____ Date _____

Moberly School District
Health Services FY2011 School Year
School Asthma Action Plan

Student Name _____ **Grade** _____ **Date of Birth** _____

1. Triggers that might start an asthma episode for this student:

- Exercise Animal Dander Cigarette smoke, strong odors Respiratory Infections
 Pollens Temperature Changes Foods _____ Emotions (e.g. when upset)
 Molds Irritants (e.g. chalk dust) Other _____

2. Control of the School Environment:

_____ Environmental measures to control triggers at school _____
 _____ Pre-Medications (prior to exercise, choir, band, etc.) _____
 _____ Dietary Restrictions _____

3. Peak Flow Monitoring

_____ Monitor Peak Flow:
 Personal Best Peak Flow _____ Monitoring Times _____
 _____ Do Not Monitor Peak Flow

4. Routine Asthma and Allergy Medication Schedule

Medication Name	Dose/Frequency	When to Administer	
		At Home	At School

5. Field Trips: Asthma Medications and supplies must accompany student on all field trips. Staff member must be instructed on correct use of the asthma medications and bring a copy of the Asthma Action Plan and Contact Phone Numbers.

(1) Parent to Contact _____
 Phone Number(s) _____
 (2) Other Person to Contact in Emergency _____
 Phone Number(s) _____

► Parent/Legal Guardian Signature _____ Date _____

Reviewed by the School Nurse _____ Date _____

Moberly School District
Health Services FY2011 School Year
School Asthma Quick Relief & Emergency Plan

****Immediate action is required when the student exhibits any of the following signs of respiratory distress. Always treat symptoms even if a peak flow meter is not available.**

Severe cough	Shortness of Breath	Sucking in of the chest wall	Difficulty walking from breathing
Chest tightness	Turning blue	Shallow, rapid breathing	Difficulty talking from breathing
Wheezing	Rapid, labored breathing	Blueness of fingernails & lips	Decreased or loss of consciousness

Steps to Take During an Asthma Episode:

1. Give Emergency Asthma Medications As Listed Below:

Quick Relief Medications	Dose/Frequency	When to Administer
1.		
2.		

2. Contact Parents if _____

3. Call 911 to activate EMS if the student has ANY of the following:

- Lips or fingernails are blue or gray
- Student is too short of breath to walk, talk, or eat normally
- No relief from medication within 15-20 minutes with any of the following signs
 - Chest and neck pulling in with breathing
 - Child is hunching over
 - Child is struggling to breathe

Parent Consent for Management of Asthma at School

I, the parent or guardian of the above named student, request that this School Asthma Action Plan be used to guide asthma care for my child. I agree to:

1. Provide necessary supplies and equipment.
2. Notify the school nurse of any changes in the student's health status.
3. Notify the school nurse and complete new consent for changes in orders from the student's health care provider.
4. Authorize the school Nurse to communicate with the primary care provider/specialist about asthma/allergy as needed.
5. School staff interacting directly with my child may be informed about his/her special needs while at school.

► Parent/Legal Guardian Signature _____ Date _____

Reviewed by School Nurse _____ Date _____