Bethel Health Assessment

Student Name ____ School ____________________________________

Date of Birth ____________________________ Date ______________ Grade _____________

ASTHMA ASSESSMENT and CARE PLAN

You have checked on school records that this student has **asthma**. It is important to have current health information & direction when she/he needs help at school. Please complete this form & return it to your child's school so that appropriate instructions may be given to school personnel. Your school nurse is available for consultation.

How often do the asthma episodes occur? ____

Most recent asthma related hospitalization/emergency room visit.____

Name of the doctor who is currently treating student's asthma: ________________________________ ______________
(Dr's phone #)

Does your child ride the school bus? ___No ___Yes Bus No. _______

Does your child participate in school sports? ____No ___Yes

LIST THE CONDITIONS THAT USUALLY BRING ON THIS STUDENT'S ASTHMA EPISODES:

___Emotional stress ___Respiratory Infection ___Exposure to Cold Air

___Exercise (describe, e.g., after running) ______________________________ Odors (describe) ______________

___Allergic reaction (describe: e.g., peanuts, carpets) ____

WHAT SYMPTOMS ARE USUALLY PRESENT IN THIS STUDENT'S ASTHMA EPISODES:

____Coughing _____Wheezing _____Shortness of Breath _____Fear _____Bluish Color of Skin/Nails

____Unable to speak a sentence without taking a breath, _____Other (describe) ________________________________

ARE MEDICATIONS NEEDED TO CONTROL THE ASTHMA? ___No ___Yes (List below the medications needed)

MEDICATIONS	AMOUNT TAKEN	WHEN AND FOR WHAT SIGNS?
1. ________________________	______________________	__________________________________
2. ________________________	______________________	__________________________________
3. ________________________	______________________	__________________________________

(Circle number of any of these medications to be taken at school.)

Is student capable of self-administering rescue inhaler? Yes__No___

Where is rescue inhaler kept? _______________________________________(K-8 school office recommended)

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THE USUAL CARE PLAN AT SCHOOL FOR A STUDENTS ASTHMA IS:

1. Assist student with prescribed medication and allow to rest.
2. Encourage student's relaxation (e.g., slow, deep breathing, sipping warm fluids).
3. Observe student for inadequate breathing; call 911/EMS if inadequate breathing is observed.
4. Call parent if medication is not helping or student is using rescue inhaler a second time in a day.

If you want additions or changes to this, please describe:____

____

Parent/Guardian Contact #1	**Emergency Contact #2**	**Emergency Contact #3**
Name ________________________	Name________________________	Name________________________
Relationship__________________	Relationship__________________	Relationship__________________
Phone: ______________________	Phone: ______________________	Phone: ______________________
Work #______________________	Work # ______________________	Work # ______________________

AMBULANCE PERMIT

I give consent for the school principal, school nurse, or other school personnel to use their judgment in securing further medical aid and to call an ambulance to take my (son, daughter) ______________________________to ______________________________Hospital in case parent/legal guardian cannot be reached.

The above information may be shared with ambulance personnel. **PERMISSION:___YES___NO**

To provide for your child's safety and educational experience the above information will be shared with school staff, included in your child's school health record and may be shared electronically.

____ ____________________

Signature of Parent/Guardian Date (Valid One Year)

RETURN THIS FORM TO THE SCHOOL
(For Staff use only below this line)

	DATE	**SIGN / INITIAL**
STUDENT COMPUTER SYSTEM ENTRY	________________	________________________
INFORMATION SHARED WITH STAFF	________________	________________________

Additional notes:____

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