**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:** _____