

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: _____

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

- Hospitalization _____
- Emergency Room _____
- Urgent Care Clinic _____

Life-threatening events:

- Intubation _____ ICU admission _____

Typical Asthma Symptoms:

- Frequency _____
- Usual signs/symptoms _____
- Usual patterns (Describe what happens) _____

- Management (what works?) _____

- 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

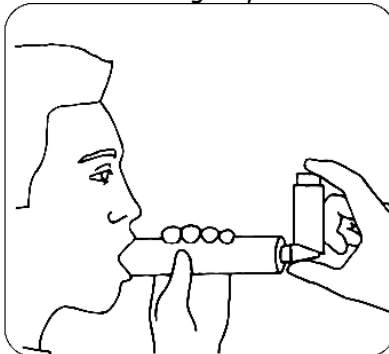
Comments: _____

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 1 minute 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 _____