FORT ZUMWALT SCHOOL DISTRICT
ASTHMA ASSESSMENT GUIDE

Date: _____

STUDENT: _____

Parents' telephone numbers:

Mom's Name: _____ (H) _____ (W) _____

Dad's Name: _____ (H) _____ (W) _____

Other emergency contact:

Name: _____ Telephone: _____

Doctor/health care provider:

Name: _____ Telephone: _____

Other Physician: _____ Telephone: _____

DAILY ASTHMA MANAGEMENT PLAN

**** Identify the things which start an asthma episode (Check each that applies to the student.)**

☐ Exercise	☐ Strong odors or fumes	☐ Pollens
☐ Respiratory infections	☐ Chalk dust	☐ Molds
☐ Change in temperature	☐ Carpets in the room	☐ Animals
		☐ Other _____

Comments: _____

**** Control of School Environment**

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.)

_____

_____

**** Peak Flow Monitoring**

Personal Best Peak Flow number: _____

Monitoring Times: _____ _____ _____

**** Daily Medication Plan**

	Name	*Amount*	*When to Use*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

EMERGENCY PLAN

Emergency action is necessary when the student has symptoms such as _____, _____,

_____, _____, or has a peak flow reading of _____.

**** Steps to take during an asthma episode:**

1. Give medications as listed below.
2. Have student return to classroom if _____
3. Contact parent if _____
4. ***Seek emergency medical care if the student has any of the following:***
   - ☑ **No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.**
   - ☑ **Peak flow of _____.**
   - ☑ **Hard time breathing with:**
     - *** Chest and neck pulled in with breathing**
     - *** Child is hunched over**
     - *** Child is struggling to breathe**
   - ☑ **Trouble walking or talking**
   - ☑ **Stops playing and can't start activity again**
   - ☑ **Lips or fingernails are gray or blue**

**** Emergency Asthma Medications**

	Name	*Amount*	*When to Use*
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Comments/Special Instructions

_____

_____

For Inhaled Medications

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____