

RCS-Kent View Elementary Asthma Management Survey

It has come to our attention that your child has/may have asthma or breathing problems. We need more information to help us take care of your child at school. Please complete both sides of this form. The second page needs to be completed by a health care provider.

Today's Date: _____ Child's Name: _____ Grade: _____ Age: _____

Parent/Guardian: _____ Home Phone Number: (____) _____

Work Number: (____) _____ Cell/Pager Number: (____) _____

Name of Physician or Health Care Provider: _____ Clinic Phone #: _____

Allergies (please list): _____ Name of allergist: _____

1. Has your child ever been diagnosed by a doctor as having asthma? Yes No

2. On a scale of 1 - 5, please rate the severity of your child's asthma: 1 = not severe and 5 = severe.

1	2	3	4	5
Not Severe		Between		Severe

3. Has your child had an episode of wheezing in the last 12 months? Yes No

4. In the last 12 months, have you heard your child wheeze or cough after active play? Yes No

5. What triggers your child's asthma or makes it worse?

Pollens	Cigarette smoke	Exercise, sports
Mold	Air pollution, ozone, coal, dust, smoke	Having a cold, sinusitis
Animals	Chalk, chalk dust	Changes in the weather
Cockroaches	Paints, cleaning agents, new furnishings	Stress, emotional upsets
Dust, dust mites	Pesticides	Foods, medications
Grain dust, alfalfa	Strong odors, perfume, dry-erase markers	
Other _____		

6. In what seasons does your child's asthma seem to be worse?

None Fall Winter Spring Summer

7. How well does your child take his/her asthma medications?

Takes medicine by self as prescribed	Often forget to take medicine
Needs help to take medicine	Not using medicine now

8. In the past month, during the day, how often has your child had coughing, wheezing, or breathing difficulties?
None 2 times a week or fewer 3-6 times a week
Everyday (at least once every day) Constantly (most or all of the time, every day)

9. In the past month, during the night, how often has your child awakened and had coughing, wheezing, or breathing difficulties?
None 2 times a month or fewer 3 - 4 times a month
Every night 5 or more times a month

10. In the past month, how many times during the week does your child use their albuterol inhaler?
More than 2 times a month 2 times a week or fewer 3 - 6 times a week 7 times a week
More than 7 times a week

11. During the past 4 weeks, how frequently has your child's asthma stopped him/her from taking part in sports, recess, and physical education, or other school activities?
Not at all unless an attack Only with a lot of activity Interferes with moderate activity
Interferes with any activity

Asthma Action Plan

(to be completed by Health Care Provider)



Check Asthma Severity:


- Intermittent
- Mild Persistent
- Moderate Persistent
- Severe Persistent


Trigger List:

- Chalk dust
- Cigarette smoke
- Colds/flu
- Dust or dust mites
- Stuffed animals
- Carpet
- Exercise
- Mold
- Ozone alert days
- Pests
- Pets
- Plants, flowers, cut grass, pollen
- Strong odors, perfume, cleaning products
- Sudden change in temperature
- Wood smoke
- Foods: _____
- Other: _____


Updated on: _____

Patient Name:	Birth Date:	Grade:	School Year:
Home Address:	City:	State:	Zip Code: Home Phone #:
Doctor/Nurse Name:	Parent/Guardian Name:		
Doctor/Nurse Phone #:	Parent/Guardian Phone #:		
List ALL medications taken ONLY at home:			

GREEN			
MEDICINE	HOW MUCH	WHEN TO TAKE	
You have <u>all</u> of these: <ul style="list-style-type: none"> • Breathing is good • No cough or wheeze • Sleep through the night • Can go to school and play 			
15 minutes before sports use this medicine to prevent symptoms _____ 2 puffs with spacer <input type="checkbox"/> YES <input type="checkbox"/> NO			

YELLOW CAUTION - Slow Down ==> Take Your Quick Relief Medicine			
MEDICINE	HOW MUCH	WHEN TO TAKE	
You have <u>any</u> of these: <ul style="list-style-type: none"> • Cough • Mild wheeze • Tight chest • Trouble breathing at night • Shortness of breath 			
IF your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hr of the quick relief treatment, THEN: <ul style="list-style-type: none"> <input type="checkbox"/> Take quick-relief medication every 4 hours for 1 to 2 days <input type="checkbox"/> Contact your physician for follow-up care 		IF your symptoms (and peak flow, if used) DO NOT return to GREEN ZONE after 1 hr of the quick relief treatment, THEN: <ul style="list-style-type: none"> <input type="checkbox"/> Take quick-relief medication again <input type="checkbox"/> Contact your physician/Health Care Provider within _____ hrs of modifying your medication routine 	

- Relax and take slow deep breaths.
- Rest in a comfortable position, but not lying down.
- If symptoms RESOLVE within 20 minutes, student may return to class.
- If symptoms PERSIST or return within a few hours, follow red zone directions & contact parent.

RED			
MEDICINE	HOW MUCH	WHEN TO TAKE	
Your asthma is getting worse fast & Medicine is not helping <ul style="list-style-type: none"> • Breathing is hard & fast • Nose opens wide • Ribs show • Can't talk well or walk • Blueness of lips 			
CALL 911 if symptoms worsen or inhaler is not helping after 15 minutes, can't walk or talk well, nostrils open wide, chest or neck pulled in or lips blue: GIVE RESCUE MEDICINE AGAIN while waiting for ambulance			

- Take Quick Relief Medicine.
- Use nebulizer if available until ambulance arrives.
- Immediate action is needed: Call an ambulance!

This represents an order for medication listed above.

- Child has been instructed to self-administer above medication.

Doctor/NP/PA Signature: _____ Date: _____

I give permission to the school nurse, my child's doctor/NP/PA or _____ to administer ordered medication, and share pertinent information about my child's asthma.

Parent/Guardian Signature: _____ Date: _____