TULSA PUBLIC SCHOOLS
HEALTH SERVICES

HEALTH ASSESSMENT DATABASE: ASTHMA

Name_____Grade_____School_____ Medical Dx_____
Age_____Teacher_____Room_____
Name of Parent/Legal Guardian or Person responsible for student's care_____
Phone (H)_____ Phone (W)_____
Address_____
Name of Parent/Legal Guardian or Person responsible for student's care_____
Phone (H)_____ Phone (W)_____
Address_____
Emergency Phone Contact #1 Name _____
Relationship to Student _____ Phone _____
Physician for this DX _____ Phone _____
Other Physician(s) _____ Phone _____

1. DAILY MANAGEMENT PLAN

A. Identify the things which trigger an attack or allergic episode. Check all that apply to the student.

_____Exercise
_____Respiratory infections
_____Change in temperature
_____Animals
_____Food
_____Other (specify) _____
_____Strong odors or fumes
_____Chalk Dust
_____Carpets in the room
_____Pollens
_____Molds
Comments _____
_____

B. Control of School Environment
List any environmental control measures, pre-medications, and/or dietary restrictions the student needs to prevent an attack or allergic episode.
_____
_____

C. Describe the attack (degree of severity, i.e. rests, takes medicines, sees doctor, visits emergency room, is hospitalized).
_____
_____

D. How often does child have an attack? _____xs/week _____xs/month _____xs/year
Time of day? _____am _____pm

E. Peak Flow monitoring (if applicable)
Personal best Peak Flow number _____
Monitoring Time _____
_____.
_____.

(over)

II. EMERGENCY PLAN

A. Emergency action is necessary when the student has symptoms such as _____, _____, _____ or has a peak flow reading of _____.

B. Steps to take during an attack or allergic episode:

1. Give medications as listed below.
2. Have student return to classroom if _____ _____
3. Contact parent/legal guardian or person responsible for student's care if _____
4. SEEK EMERGENCY MEDICAL CARE IMMEDIATELY IF THE STUDENT HAS ANY OF THE FOLLOWING:
   - _____ No improvement 15-20 minutes after initial treatment with medicine and the emergency contact 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 cannot start activity again
   - _____ Lips or fingernails are gray or blue
   - _____ Other

C. EMERGENCY MEDICATIONS:

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

Comments/Special Instructions

_____

Signature of Parent/Legal Guardian or Person responsible for student's care _____
Date _____

Physician Signature (if required) _____
Date _____

Nurse's Signature _____
Date _____

Teacher's Signature (if required) _____
Date _____

Principal's Signature or Designee (if required) _____
Date _____

***THIS PLAN MUST BE REVIEWED AND UPDATED EACH SCHOOL YEAR**

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