ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Student Services/ St. Mary's County Health Department

ASTHMA PROCEDURE INFORMATION

Date: _____

To the Parent(s)/Legal Guardian(s) of: _____ Grade: _____

Please answer the following:

1. When was the diagnosis made? _____
2. Do you consider the asthma condition serious or life threatening? ☐ Yes ☐ No
   If Yes, an Emergency Asthma Action Plan may be needed at school.
3. How many times has your child been hospitalized overnight or longer for asthma in the past year? _____
4. How often does your child have a severe episode? _____
5. What triggers your child's asthma attacks? (Please check any that apply.)
   - ☐ Illness
   - ☐ Emotions
   - ☐ Medications
   - ☐ Chemical Odors
   - ☐ Weather
   - ☐ Exercise
   - ☐ Foods
   - ☐ Cigarette/Other Smoke
   - ☐ Fatigue
   - ☐ Dust
   - ☐ Cold/Dry Air
   - ☐ Other _____
   - ☐ Allergies (Please list.)

   _____

   _____
6. What signs and symptoms does your child experience? (Please check any that apply.)
   - ☐ Cough
   - ☐ Wheeze
   - ☐ Chest tightness
   - ☐ Shortness of breath
   - ☐ Difficulty breathing
   - ☐ Rapid breathing
   - ☐ Pale skin color
   - ☐ Blue skin color
   - ☐ Fatigue
   - ☐ Difficulty walking/talking
   - ☐ Sweating
   - ☐ Anxiety, restlessness, and apprehension
   - ☐ Nasal flaring and drawing in of neck and check muscles
7. Please list the medications your child takes for asthma (everyday and as needed).

   Name of Medication Dose Frequency

   (In School) _____

   _____

   If medication is needed at school, please have your doctor complete a Medication Authorization form.

   (At Home) _____

   _____
8. What if any side effects does your child have from taking his/her medications?

   _____

   _____
9. What measures do you want your child to take if he/she has an asthma attack at school?
   - ☐ Breathing exercises
   - ☐ Rest/relaxation
   - ☐ Drinks liquids
   - ☐ Notify parent(s)/legal guardian(s)
   - ☐ Other (Please describe.) _____

   Takes medication:
   - ☐ Inhaler
   - ☐ Nebulizer
   - ☐ Oral medication
10. Does your child require medications by nebulizer at home? ☐ Yes ☐ No
11. Will your child be using a peak flow meter at school? ☐ Yes ☐ No
    What is your child's baseline peak flow rate? _____
12. Are there any activity restrictions? ☐ Yes ☐ No
13. Does your child understand asthma and what he/she should do to manage it? ☐ Yes ☐ No
14. How often is your child evaluated by the physician for asthma?

    _____ Date of last visit _____

Parent(s)'/Legal Guardian(s)' Signature _____ Date _____