Inspiring Excellence
LAKE STEVENS
School District

Lake Stevens School District | 12309 22nd St. NE | Lake Stevens, WA 98258-9500
425-335-1500 (office) | 425-335-1549 (fax)

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 your 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 ▢Both Please Describe__________________________________
   ▢Continual ▢Episodic ▢Both Please Describe____
   ▢Daily Variations, especially at night or upon awakening_____________________________________
   Onset of symptoms, duration, frequency (# of days/nights per week or month)____________________
   ____

3. **Precipitating and/or aggravating factors (Triggers)**
   ▢Viral Respiratory Infections/Colds ▢ Environmental Allergens (pollen/dust)
   ▢Exercise ▢Irritants (tobacco smoke, strong odors, chemicals)
   ▢Weather Changes (exposure to cold air) ▢Animal Dander or Feathers
   ▢Foods, Additives or Preservatives ▢Emotions (fear, anger, crying, laughing)
   ▢Drugs (Aspirin, NSAIDS, Beta Blockers, Etc.)
   ▢Other ____
   **if checked, please describe____
   ____

4. **Development of disease and management/treatment**
   Age of onset / diagnosis of Asthma ____
   Use of Peak Flow Meter? (Frequency, Current Readings)___________________________________
   Current Medications (Name, Dose, Frequency)____
   ____
   Need for oral corticosteroids and frequency of use_______________________________________
   Typical Symptoms
   - Frequency____
   - Usual signs/symptoms____
   - Management (What works?)____

CONTINUED ON REVERSE

- Limitations of activity____

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_______________

Provider Treating Asthma_________________________________ Phone Number ________________

Episodes of unscheduled care (Dates and lengths of time in the past 12 months)

- Urgent Care Clinic____
- Emergency Room Visit____
- Hospitalization____
- Number of school/work days missed due to asthma________________________

Life-threatening events

- Intubation_____________________________ ICU admission_____________________________

5. Social history of student/family

Members of household____

____

Family members with chronic health conditions________________________________

____

Smoking in the home ☐Yes ☐No Pets in the home ☐Yes ☐No Type_________________

____

6. Child's knowledge of condition

Does your child understand asthma triggers and reliably report difficulty? ☐Yes ☐No

Comments____

Does your child know how to use inhaler properly? ☐Yes ☐No

Did your physician instruct your child on proper use of the inhaler? ☐Yes ☐No

Please keep my child's teacher and staff that may be involved with my child updated on his/her asthma care. I am aware that if an Emergency Care Plan is indicated by the nurse, that it will need to be updated yearly.

NOTES: ____

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Parent Signature____ Date_______________

Nurse referral for Emergency Care Plan ☐Yes ☐No

Nurse Signature____ Date_______________